

Missouri

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND
PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 09/27/2017 12:58:57 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State SAPT DUNS Number

Number 7808714300

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Missouri Department of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address PO Box 687

City Jefferson City

Zip Code 65102-0687

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Mark

Last Name Stringer

Agency Name Missouri Department of Mental Health

Mailing Address PO Box 687

City Jefferson City

Zip Code 65102-0687

Telephone 573-751-9499

Fax 573-751-7814

Email Address mark.stringer@dmh.mo.gov

State CMHS DUNS Number

Number 780871430

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Missouri Department of Mental Health

Organizational Unit Division of Behavioral Health

Mailing Address P.O. Box 687

City Jefferson City

Zip Code 65102-0687

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Mark

Last Name Stringer

Agency Name Missouri Department of Mental Health

Mailing Address P.O. Box 687
City Jefferson City
Zip Code 65101-0687
Telephone 573-751-4942
Fax
Email Address mark.stringer@dmh.mo.gov

III. Third Party Administrator of Mental Health Services

First Name
Last Name
Agency Name
Mailing Address
City
Zip Code
Telephone
Fax
Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From
To

V. Date Submitted

Submission Date 8/29/2017 8:58:01 AM
Revision Date 9/27/2017 12:57:39 PM

VI. Contact Person Responsible for Application Submission

First Name Christie
Last Name Lundy
Telephone 573-526-1636
Fax 573-751-7814
Email Address christie.lundy@dmh.mo.gov

Footnotes:

Missouri does not have any third party administrators handling the MHBG funds.



ERIC R. GREITENS
GOVERNOR

GOVERNOR OF MISSOURI
JEFFERSON CITY
65102

P.O. Box 720
(573) 751-3222

April 12, 2017

Odessa F. Crocker
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse Mental Health Services Administration
5600 Fishers Lane, 17th Floor
Rockville, Maryland 20850

Dear Ms. Crocker:

As the Governor of the State of Missouri, I delegate signatory authority to the current Director of the Department of Mental Health, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the following grants from the Substance Abuse and Mental Health Services Administration ("SAMHSA"):

- 1) Substance Abuse Prevention and Treatment Block Grant ("SABG");
- 2) Community Mental Health Services Block Grant ("MHBG"); and
- 3) Projects for Assistance in Transition from Homelessness ("PATH") Grant.

The Director may also sign the Annual Synar Report.

This delegation of signatory authority holds until such time as I may modify or rescind it.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric R. Greitens", written over a horizontal line.

Eric R. Greitens
Governor

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee¹: _____

Title: Department Director

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

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Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
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as authorized by
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

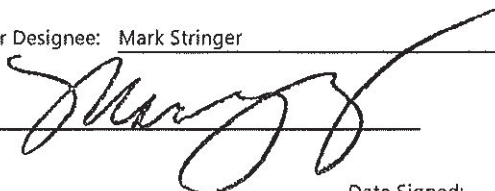
The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee¹:



Title: Department Director

Date Signed:

07/22/2017

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Printed: 7/27/2017 4:33 PM - Missouri

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

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Section	Title	Chapter
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Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
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14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee¹: _____

Title: Department Director

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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Name of Chief Executive Officer (CEO) or Designee: Mark Stringer

Signature of CEO or Designee¹: 

Title: Department Director

Date Signed: 07/27/2017

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Printed: 7/27/2017 4:33 PM - Missouri

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<div>Mark Stringer</div>
Title	<div>Department Director</div>
Organization	<div>Missouri Department of Mental Health</div>

Signature:

Date:

<div><div>Footnotes:</div><div>Not applicable.</div></div>
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Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Missouri's Behavioral Health System of Care

Overview and structure

With a population of about six million people, Missouri provides a rich diversity of rural and urban landscapes. The state has 114 counties plus the city of St. Louis. Approximately 83.3 percent of the population is Caucasian, 11.8 percent are African-American, 2.0 percent are Asian, and 2.9 are of multi-race or other race. About 4.1 percent of the state's population is Hispanic (U.S. Census Bureau, 2017). Large populations of African-Americans are present in the state's metropolitan areas of St. Louis and Kansas City as well as the rural southeast "Bootheel" area. The state's largest Hispanic population is in the Kansas City area. Although the state does not have any federally recognized tribes, small populations of Native Americans make their home near the Oklahoma border. Approximately 494,346 Missouri residents are veterans (Missouri Department of Public Safety, 2017).

At \$261.5 billion, Missouri's Gross State Product (GSP) in 2015 ranked 21st among states. As of April 2017, the state's unemployment rate stood at 4.5 percent which is slightly lower than that for the country as a whole (5.0%) (Missouri Department of Economic Development, 2017). Missouri has 26 counties plus the city of St. Louis that have poverty rates of at least 20 percent (USDA Economic Research Service, 2017). Most of these counties are located in the southern portion of the state.

The Missouri Department of Mental Health (DMH) is one of sixteen state agencies under the executive branch of state government. DMH collaborates on initiatives with other state agencies including the Departments of Corrections (DOC), Transportation, Elementary and Secondary Education (DESE), Health and Senior Services (DHSS), Public Safety (DPS), and Social Services (DSS). DSS is the Medicaid authority for the state. DMH's close, collaborative relationships with DOC and DSS, in particular, are strengths to the state's behavioral health system. The principal missions for DMH as established in state law are to: 1) prevent mental disorders, developmental disabilities, substance abuse, and compulsive gambling; 2) treat, habilitate, and rehabilitate Missourians who have these conditions; and 3) improve the public understanding and attitudes about mental disorders, developmental disabilities, substance abuse, and compulsive gambling. DMH has representation on various interagency groups including:

- Child and Family Services Review Advisory Committee;
- Children and Youth in Disasters Committee;
- Comprehensive System Management Team (for state agencies providing services to children);
- Corrections Oversight Committee for Behavioral Health Services;
- Council for Adolescent School Health;
- Early Childhood Comprehensive System Steering Committee;
- Eating Disorders Council;
- Governor's Committee to End Homelessness;
- Governor's Faith-based and Community Service Partnership for Disaster Recovery;
- Impaired Driving Subcommittee, Coalition for Roadway Safety;
- Juvenile Crime Enforcement Coalition for Missouri School Violence Hotline;
- Maternal, Infant and Early Childhood Home Visiting Program State Steering Committee;

- Midwest Consortium on Problem Gambling and Substance Abuse Committee;
- Missouri Affiliate of the NO Fetal Alcohol Syndrome (NOFAS);
- Missouri Alliance for Drug Endangered Children;
- Missouri Alliance to Curb Problem Gambling;
- Missouri Behavioral Health Alliance;
- Missouri Behavioral Health Epidemiology Workgroup;
- Missouri Coordinated School Health Coalition;
- Missouri Drug Court Coordinating Commission;
- Missouri HIV/STD Prevention Community Planning Group;
- Missouri Injury and Violence Prevention Advisory Council;
- Missouri Lifespan Respite Coalition;
- Missouri Prevention Partners Coalition;
- Missouri Reentry Process Steering Team;
- Missouri Task Force on Children's Justice;
- Mo HealthNet (Medicaid) Behavioral Health Committee for Health Care Reform;
- Mo HealthNet (Medicaid) Managed Care Quality Assurance & Improvement Advisory Group;
- Opioid Prescription Intervention (OPI) Workgroup;
- Paula J. Carter Center on Minority Health and Aging;
- Prescription Drug Misuse Workgroup;
- Sexual Violence Prevention Planning Stakeholders Committee;
- Show Me Response (disaster & emergency coordination);
- Stakeholders Advisory Group;
- State of Missouri Brain Injury Advisory Council; and the
- Task Force on the Prevention of Sexual Abuse of Children.

Historically, DMH has had the Divisions of Alcohol and Drug Abuse (ADA), Comprehensive Psychiatric Services (CPS), and Developmental Disabilities (DD). In January 2013, ADA and CPS integrated into a new division: the Division of Behavioral Health (DBH). The Department's supportive offices include the Offices of Deaf Services, Constituent Services, and Comprehensive Child Mental Health. In November 2012, Missouri voters approved a measure that prohibits the Governor or any state agency from establishing or operating a state-based health insurance exchange without legislative or voter approval. As of July 2017, Missouri has not expanded Medicaid coverage to 138% of the federal poverty level.

The director of the Department of Mental Health (DMH) is appointed by the Missouri Mental Health Commission and confirmed by the state Senate. Comprised of seven members appointed by the Governor, the Mental Health Commission serves as the principal policy advisory body to the department director. The Commission, by law, must include an advocate of community mental health services, a physician who is an expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, and a citizen who represents the interests of consumers of developmental disabilities services. Each of the DMH divisions report progress on identified performance measures to the Mental Health Commission on a quarterly basis.

The Department Director appoints the division directors. The director of the Division of Behavioral Health (DBH) is responsible for leading and managing the DBH division; directing policy and strategic plans for DBH; coordinating with other state officials; and representing DBH in discussions, negotiations and partnerships with other state and federal organizations. DBH is organized into the following functional units:

- Community Programs,
- Psychiatric Facility Operations,
- Children's Services,
- Recovery Services,
- Prevention and Mental Health Promotion,
- Administration, and
- Regional Operations.

Community Programs

Included under Community Programs are all mental health and substance abuse community-based treatment programs, the Substance Abuse Traffic Offenders' Program (SATOP), Healthcare Homes, certification, and fidelity review. In addition to leading and managing these programs, the Director of Community Programs is also responsible for working with key stakeholders, to include other state agencies, to improve community-based services. In 2012, the Department of Mental Health (DMH) hired a Project Manager to oversee behavioral health services for Missouri's veteran population. The Division of Behavioral Health (DBH) contracts with 58 community-based agencies for the provision of substance abuse treatment and/or psychiatric rehabilitation services: 29 for substance abuse treatment only, 15 for psychiatric rehabilitation services only, and 14 for both. The certification standards of care contain core rules, adopted in 2001, which apply to both mental health and substance abuse programs. DBH staff conduct annual reviews of contracted community organizations. DBH certifies 60 organizations for substance abuse treatment, 16 organization for substance abuse prevention, and 49 organizations for mental health treatment.

The Department of Mental Health's (DMH) value statement specifies that "Missourians participating in mental health services are valued for their uniqueness and diversity and respected without regard to age, ethnicity, gender, race, religion, sexual orientation, or socioeconomic condition" (DMH, 2008). Core standards require that services be delivered in a manner that is responsive "to each individual's age, cultural background, gender, language and communication skills, and other factors, as indicated" (9 CSR 10-7.010). DMH requires through contract language that contractor staff be competent in the cultural, racial, and ethnic patterns of the geographic area being served. Interpreting services are provided to individuals in treatment whose preferred language is a language other than spoken English. DMH's Office of Deaf Services (ODS) is responsible for consultation and technical assistance to DMH facilities and contracted providers delivering behavioral health services to eligible individuals who are deaf, hard of hearing or from cultural minority groups. The ODS also establishes minimum competencies for behavioral health interpreters, consistent with the federal Culturally Linguistically Appropriate Services Standards. Client complaints and grievances received either by DMH's Office of Constituent Services or by the provider organization are reviewed by DMH clinical staff for issues with cultural competency. DMH's information system collects data on client characteristics including race, ethnicity, preferred language, hearing status, and gender

identity (ISO 5218). Such data is aggregated by geographical areas for analysis. DMH is a provider of cultural competency trainings for the state's behavioral health and prevention workforce. Cultural competency training is included in DMH's annual Spring Training Institute that is attended by approximately 800 behavioral health and human service professionals.

All individuals needing behavioral health services from facilities operated by the Division of Behavioral Health (DBH) or contracted service providers receive an initial assessment. For individuals needing substance abuse treatment, an individual receives a structured interview completed by a Qualified Substance Abuse Professional (QSAP). For individuals seeking services from the SATOP program, the self-administered Driver Risk Inventory II (DRI-II), in conjunction with an individualized interview with a QSAP, determines the level of program placement. For individuals needing substance use or mental health treatment, the Daily Living Activities (DLA-20) functional assessment tool is used with different modules for adults and youth age 6 to 18.

DBH substance abuse treatment programs include the Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for Women and Children (12 contracts), the General Population (34 contracts), the Opioid Program (4 contracts), and Adolescents (17 contracts). DBH's CSTAR programs are the only substance abuse treatment programs reimbursable by Medicaid in the state. The CSTAR programs offer a flexible combination of clinical and supportive services that vary in duration and intensity depending on the needs of the client. All but the Opioid programs offer a residential component for individuals needing that type of structure and support. Available services include assessment; individual and group counseling; group education; community support; residential or housing support, as appropriate; trauma-specific individual counseling and group education; individual co-occurring disorders counseling; family therapy; and medications, physician and nursing services to support medication therapy. In addition, families can also participate in individual and group codependency counseling. The Opioid programs provide outpatient services to individuals addicted to opiates and include the dispensing of clinically appropriate medications, primarily methadone, to prevent withdrawal and/or relapse. A designated Program Specialist, acting as the State Opioid Treatment Authority (SOTA), provides oversight and clinical assistance to the Opioid programs to ensure that treatment is consistent with best practices and federal requirements. In 2011, DBH was successful in amending the Medicaid state plan to include a CSTAR Modified Medical Detoxification Program (13 contracts). DBH also maintains the Primary Recovery Plus (PR+) program (10 contracts). Modeled after the CSTAR General Population Program, PR+ offers a full continuum of services within multiple levels of care to assist those individuals without Medicaid coverage. DBH oversees several programs designed specifically for Department of Corrections' offenders under community-supervision who need substance abuse treatment. These include a CSTAR Women and Children Alternative Care (2 contracts), Community Partnership (1 contract), and Free N Clean (1 contract). As established in contracts, priority populations for substance abuse treatment include:

- Women who are pregnant;
- Intravenous (IV) drug users who have injected drugs in the prior 30 days;
- Civil involuntary commitments;
- High risk offenders referred by the Department of Corrections' institutions and Division of Probation and Parole via referral form and protocol;

- Applicants and recipients of Temporary Assistance for Needy Families (TANF) referred by the Department of Social Services, Family Support Division, via referral form and protocol; and
- Adolescents and families served through the Children's System of Care.

All contracted agencies providing substance abuse treatment are required to screen individuals requesting services to determine potential eligibility as a priority population and/or a crisis situation. Individuals identified as a priority population who request or are referred to treatment must be assessed and admitted to an appropriate level of care within 48 hours of initial contact or scheduled release date, whichever is later. Otherwise, the provider must initiate interim services. Pregnant women and civil involuntary commitments, however, require immediate admission. Pregnant women are to be referred to a CSTAR Women and Children's Program unless there is clinical justification to admit her to a general treatment program.

DBH's SATOP program serves more than 24,700 DWI offenders annually who are referred as a result of an administrative suspension or revocation of their driver's licenses, court order, condition of probation, or plea bargain. SATOP is, by law, a required element in driver license reinstatement by the Department of Revenue. The mission of SATOP is to: A) inform and educate DWI offenders as to the hazards and consequences of impaired driving; B) promote safe and responsible decision-making regarding driving; C) motivate for personal change and growth; and D) contribute to the public health and safety of Missourians. DBH certifies and monitors SATOP programs which offer varying levels of care. All SATOP consumers receive an assessment by an Offender Management Unit to determine the level of intervention required. The levels of service include: a 10-hour education course (level 1), a 20-hour intervention course consisting of intensive education and group counseling (level 2), a 50-hour outpatient counseling program for adults or a 25-hour program for youth (level 3), and traditional treatment (level 4). The Serious and Repeat Offender Program (SROP) (level 4) has been designed for chronic DWI offenders and consists of at least 75 hours of treatment in no less than 90 days. The SROP programs have referral agreements with the state's 55 DWI courts/hybrid courts approved by the Drug Court Coordinating Commission. SATOP is largely funded by offender fees.

Core services for the Division of Behavioral Health's (DBH) Community Psychiatric Rehabilitation Program (CPR) (28 contracts), targeted case management (18 contracts), and supported community living (251 contracts) are provided in a community-based and consumer-centered manner. Services provided in DBH's Community Psychiatric Rehabilitation Program (CPR) for adults (28 contracts) and youth (21 contracts) are Medicaid reimbursable. The types of services provided in the CPR program include evaluation, crisis intervention, community support, medication management, and psychosocial rehabilitation. Outpatient community-based services provide the least-restrictive environment for treatment. Day treatment offers the least-restrictive care to individuals diagnosed as having a psychiatric disorder and requiring a level of care greater than that provided in outpatient services but not at a level requiring full-time inpatient services. Day treatment may include vocational education, rehabilitation services, and education services. Moderate-term placement in residential care provides services with non-acute conditions who cannot be served in their own homes. Individuals whose psychiatric needs cannot be met in the community and who require 24-hour observation and treatment are placed in inpatient treatment. These services are considered appropriate for persons who may be a danger to themselves or others because of their mental disorder. DBH also oversees Community

Mental Health Treatment (CMHT) (29 contracts) for Department of Corrections' (DOC) offenders under community supervision and who have mental illness. Target populations for mental health treatment include:

- Forensic clients pursuant to Chapter 552 RSMo;
- Adults, children, and youth with serious mental illness (SMI) being discharged from DBH operated inpatient facilities, being transitioned from DBH-operated or contracted residential settings, being transitioned from DBH alternatives to inpatient hospitalization;
- Adults, children, and youth at risk of homelessness;
- Children and youth referred through the Custody Diversion Protocol;
- Individuals with a clinical or personality disorder, other than a principal diagnosis of substance abuse or mental retardation, who also qualify as an adult with severe disabling SMI or children and youth with serious emotional disturbance (SED), as defined by the Department.

DBH supports Assertive Community Treatment (ACT), a service-delivery model that provides comprehensive, community-based treatment to people with serious and persistent mental illnesses who: 1) are high users of inpatient beds, 2) often have co-occurring alcohol and drug diagnoses, 3) have involvement with the criminal justice system, and/or 4) are homeless. ACT provides highly individualized, intensive services directly to consumers in their homes and communities as opposed to a psychiatric unit. ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. DBH contracts with eight agencies to provide ACT.

For mental health treatment, the state is divided into 25 mental health service areas each with an administrative agent. These administrative agents are responsible for the assessment and provision of services either directly or through affiliate Community Mental Health Centers (CMHC) for individuals residing in the assigned service areas. The Administrative Agents are also required to have cooperative agreements with the state-operated inpatient hospitals and are responsible for the provision of follow-up services for persons released from the state hospitals. Of the 29 CMHC's, 27 are also contracted for Health Homes which was implemented in January 2012. For substance abuse treatment, individuals access services directly from the contracted service provider and may seek services anywhere in the state regardless of their county of residence. DBH funds ten regional Access Crisis Intervention Hotlines that are staffed by mental health professionals 24 hours per day and 7 days per week to provide intervention and referral for persons experiencing a behavioral health crisis. DBH has arrangements with local taxing authority boards who have a Mental Health Mil tax or Children's Services tax to fund mental health services for adults (4 counties plus the city of St. Louis) and youth (4 counties) and substance abuse treatment for adults (4 counties) and youth (2 counties plus the city of St. Louis). Five regional offices provide consultation and technical assistance to community-based service providers and conduct regular reviews of provider systems.

DBH has implemented several programs to improve coordination of consumers' primary and behavioral healthcare. Disease Management 3700 started as a two-year collaborative demonstration project between DBH and the state Medicaid authority, MO HealthNet. Medicaid eligible individuals with co-occurring chronic medical conditions and serious and persistent

mental illness, who are not current consumers of DBH, and who have had a minimum of \$30,000 annual Medicaid claims are invited to participate. Persons successfully outreached and engaged through the project are enrolled in a CMHC and assigned a Community Support Specialist. The Disease Management program served as model for Missouri's Health Home initiative and the Alcohol and Drug (ADA) Disease Management. The ADA Disease Management program began in February 2014 and targets Medicaid-enrolled adults with substance use disorders and high medical costs who are not currently engaged in treatment.

Missouri has two types of healthcare homes: 1) the CMHC's and 2) primary care including the Federally Qualified Health Centers, Rural Health Clinics, and Hospital-Operated Primary Care Clinics. Enrollment in the CMHC Health Homes began in January 2012. Eligible individuals must be covered by MO HealthNet and have 1) a serious and persistent mental illness, 2) a mental health condition and a substance abuse disorder, or 3) a mental health condition or a substance abuse disorder and a chronic health condition. Of those enrolled, approximately 85 percent are adults and 15 percent are children or youth. As a Health Home, the CMHC's provide comprehensive case management, care coordination and health promotion, patient and family support, comprehensive transitional care, and referrals to community and support services.

Psychiatric Facility Operations

Facility Operations includes management oversight of the seven state-operated psychiatric facilities – one children and six adult hospitals. With limited exceptions, state operated facilities provide intermediate or long term stay inpatient hospital treatment for individuals with complex, treatment resistant mental illness and whose illness, treatment and recovery are complicated with legal issues and constraints. Adult facilities are located in St. Louis (2), St. Joseph, Fulton, Kansas City, and Farmington. The youth facility is located in St. Louis. At the end of FY 2017, the number of staffed beds included 874 adult psychiatric inpatient, 28 youth psychiatric inpatient, 228 forensic (sexual offender) inpatient, 68 adult residential, and 16 youth residential beds.

Forensic services provides evaluation, treatment and community monitoring under the order of the circuit courts for individuals with mental illness and developmental disabilities involved in the criminal justice system. DBH provides four levels of security (maximum, intermediate, minimum, and campus), with the desired goal of progressive movement through the security continuum based on clinical condition and risk assessment. Within this continuum, forensic clients are provided treatment in a setting consistent with both the clinical needs of the client and safety of the public. Forensic programs are located at Southeast Missouri Mental Health Center, St. Louis Psychiatric Rehabilitation Center, Northwest Missouri Psychiatric Rehabilitation Center, and Fulton State Hospital. Forensic Case Monitors provide community monitoring, as required by state statute, to forensic clients acquitted as not guilty by reason of mental disease or defect who are given conditional releases by circuit courts. There are approximately 400 forensic clients on conditional release statewide.

Children's Services

Both substance abuse and mental health services for children are coordinated under the Division of Behavioral Health (DBH) Director of Children's Services. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbances (SED). These community-based services are designed to

maximize independent functioning and promote recovery and self-determination. The Daily Living Activities Functional Assessment (DLA20) Youth Version is utilized as the standardized functional tool for children and youth entering CPR services. The DLA20 is a twenty-item functional assessment measure designed to assess what daily living areas are impacted by SED or disability. The assessment tool quickly identifies where outcomes are needed so clinicians/community support specialists can address those areas on the individualized treatment plan with the goal of improved functioning and symptom reduction. An assigned Community Support Specialist monitors medical, dental, and support service needs and coordinates services and resources among community agencies. The CPR program includes an intensive level of care for acute psychiatric episodes as clinically appropriate. Approximately 90 percent of the youth receiving mental health treatment are in the CPR program. Community support services available to children and youth include day treatment, psychosocial rehabilitation services, intensive/non-intensive targeted case management, family support, and family assistance. Day treatment provides goal-oriented therapeutic services focusing on the stabilization and management of acute or chronic symptoms which have resulted in functional deficits. Day treatment may include physician services, psychiatric evaluations, medication management, age appropriate education services, skill building groups, individual and group psychotherapy, occupational/physical therapies, community support, and family support. Psychosocial rehabilitation services are a combination of goal-oriented and rehabilitative services provided in a group setting. Family support helps establish a support system for parents of children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. With family assistance, a Family Assistant Worker may work with the individual and family on home living and community skills, communication and socialization, and conflict resolution.

In 2012, Professional Parent Home (PPH) services were added to the CPR array of services offered to youth. PPH exists to serve youth in a private home whose serious emotional needs lead to behaviors, that in the absence of such programs, they would most likely be placed in restrictive residential or inpatient settings. These youth have demonstrated an inability to be in the community free of emotional or physical difficulty and who, without a sustained intensive therapeutic intervention, would have significant physical, emotional, or relational consequences. PPH providers are responsible for participation in the development of the youth's treatment plan and record documentation related to implementation of the treatment plan within the home.

In 2013, DBH offered an introductory training to providers across the state on a specialized Assertive Community Treatment (ACT) service targeted for the transitional age youth (ages 16-25) population. The first Missouri Assertive Community Treatment Transitional Age Youth (ACT TAY) program was developed in the Central Region and began providing services to this population in January 2014. The ACT TAY program uses a team approach designed to provide comprehensive and flexible treatment, support, and rehabilitation services to transitional age youth in their natural living settings rather than in hospital or clinic settings. The multi-disciplinary team members include a physician, nurse, vocational specialist, substance use specialist, peer specialist and community support specialist. Missouri has seven ACT TAY programs.

For children and youth, the first signs of mental illness or emotional distress can emerge in the school environment. DBH has expanded the availability and accessibility of treatment services by authorizing the delivery of designated CPR services in school settings. These designated CPR services are provided to children with an Individualized Education Plan (IEP), as well as those without an IEP. DBH providers partnering with schools is effective because it enables specialists to quickly identify student issues and immediately triage care based on the severity of circumstances. Besides the students getting immediate assistance, the school personnel benefit from having CPR services provided in the school setting.

Substance use treatment for adolescents is provided in the CSTAR Adolescent program. Designed for youth age 12 to 17, the CSTAR Adolescent program offers a full spectrum of treatment services. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Youth in residential settings are offered academic support services to minimize disruptions in their education. For youth with co-occurring mental health and substance use disorders, CPR and CSTAR Adolescent programs will coordinate services. In the CSTAR Women and Children Program, daycare, codependency counseling, and community support services are available to those children whose parent is receiving substance use treatment.

The Department of Mental Health (DMH) is partnering with the Department of Social Services (DSS) and the Office of State Courts Administrator (OSCA) to update and improve the existing custody diversion process established for child-serving agencies to follow in those cases involving parents who are considering voluntarily relinquishing custody of their child for the sole purpose of accessing mental health care. For those children already in state custody solely for mental health services in the absence of child abuse or neglect and severe mental retardation disability, DMH and DSS have facilitated an evaluation and review process. DSS' Children's Division has established Family Support Teams for children identified to determine future custody status. In conjunction with the diversion protocol, voluntary placement under Title IV-E allows a family to relinquish physical custody but retain legal custody so that these children become eligible for mental health services funded by Medicaid and Title IV-E funds for a period of up to 180 days. The Comprehensive Children's Mental Health Plan and grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) have supported the development of local interagency teams to oversee children's services in the community. Missouri currently has 20 local System of Care (SOC) teams.

Recovery Supports

The Division of Behavioral Health's (DBH) functional area of Recovery Services includes housing, employment, peer services, the Missouri Access to Recovery program, staff training and development, and coordination of the ADA and CPS state advisory councils. The Director of Recovery Services oversees DBH's housing unit who works to connect homeless individuals who are challenged with behavioral health issues with safe, decent, and affordable housing options that best meet their individual and family needs. In addition to providing education and technical assistance, DBH's housing unit manages 42 U.S. Department of Housing and Urban Development (HUD)-funded Shelter Plus Care Grants that provides rental assistance for individuals who 1) are homeless, 2) have a serious mental illness, a chronic substance abuse problem, a severe and chronic developmental disability, or a diagnosis of HIV/AIDS, 3) are receiving long-term behavioral health support services, and 4) meet the "very low" income

requirement. Approximately 3,000 persons are served annually through Missouri's Shelter Plus Care program. Missouri has eleven federally-funded Projects for Assistance in Transition from Homelessness (PATH) grants to support service delivery to adults (age 18 or older) with serious mental illness, as well as those with co-occurring substance abuse disorders, who are homeless or at risk of becoming homeless. Services include community-based outreach; support services such as case management, employment skills training, psychosocial education, and group therapy; and some temporary housing services. Supported community living programs are provided for persons with mental illness who do not have a place to live or who need more structured services while in the community. Persons in these programs receive support through case management and community psychiatric rehabilitation programs provided by administrative agents.

DBH recognizes the tremendous therapeutic value of employment for working-age individuals with behavioral health disorders and is committed to enhancing employment options for those individuals. Supported Employment is an evidence-based practice that provides individualized services and supports to an individual in competitive employment to promote stable employment. DBH received a Johnson and Johnson grant for the provision of technical assistance and fidelity for Supported Employment. Although the grant ended in 2012, fidelity efforts are being sustained. DBH works with the Department of Elementary and Secondary Education, Vocational Rehabilitation (Voc Rehab) who provides job counseling, job-seeking skills, job placement, and vocational training. DBH also provides support services for mental health clients not currently eligible or ready for services from Voc Rehab. The Department of Mental Health's (DMH) Employment Workgroup has facilitated the development of benefits planning training materials and a web-based tool "Disability Benefits 101". In 2012, DBH staff developed a guidance document on appropriate community support interventions reimbursable under the CSTAR treatment program for consumers pursuing employment (DMH, 2012).

Peer services are available to individuals in mental health treatment to aid in the navigation of Medicaid program and establish linkages to other community resources. Missouri has certified over 290 Peer Specialists some of whom work at Community Mental Health Centers and state-operated hospitals. DBH funds through competitive bid 5 consumer-operated drop-in centers and 5 peer support phone lines that emphasize self-help for individuals with mental illness. These Consumer Operated Service Programs (COSP) use the Fidelity Assessment Common Ingredient Tool (FACIT) as a self-assessment tool to support continuous quality improvement efforts. Missouri was one of seven study sites for SAMHSA's Multi-Site Research Initiative to assess how consumer-operated service programs can, as an adjunct to traditional mental services, improve outcomes of adults with serious mental illness. The Missouri Institute of Mental Health was one of two coordinating centers for this initiative. Family Support Provider is a peer to peer service that provides support to parents/caregivers who have children with SED. Activities may include, but are not limited to, problem solving skills, emotional support, dissemination of information, linkage to services, and parent-to-parent guidance. Peer services are available to individuals in recovery from substance use disorders. Provided by credentialed Recovery Support Specialists, recovery coaching is the development of a supportive peer relationship to foster recovery-oriented problem solving skills. The recovery coach's role emphasizes reconnection to support systems in the community. Missouri has credentialed 231 Peer Recovery Support Specialists. In 2012, DBH worked with the Addiction

Technology Transfer Center Network (ATTC) to bring the Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy to Missouri.

At this time, DBH has separate State Advisory Councils (SAC) for substance abuse and mental health. Each SAC is comprised of 25 members who advise and make recommendations to improve the system of care. Meetings typically include budget and programming updates from DBH staff as well as in-depth presentations and discussions on initiatives and strategic planning. Members have professional, research, and/or personal interests in the respective area. Membership on the Substance Abuse SAC must be at least one-half clients and/or family members of clients and have at least one member representing veterans and military affairs. Current membership includes representation from the Missouri National Guard, the Veteran's Administration, the Department of Corrections, the Department of Health and Senior Services, Drug Court, vendors, and people with lived experiences. Membership on the Mental Health SAC must have a majority of mental health clients and/or family members of clients and also representation from the Departments of Social Services, Medicaid, Corrections, Vocational Rehabilitation, Education, Housing, and Mental Health. Since work began to integrate the ADA and CPS divisions, the councils have held joint meetings on the integration process and state planning efforts for a behavioral health system of care. The December 2016 joint meeting reviewed a draft of the FY 2018 – 2019 Block Grant Behavioral Health State Plan.

Prevention and Mental Health Promotion

Prevention and Mental Health Promotion includes substance abuse prevention, suicide prevention, Crisis Intervention Teams (CIT), Mental Health First Aid, tobacco cessation, and tobacco retailer education. The Director of Prevention and Mental Health Promotion is also the project coordinator for the state's FDA tobacco enforcement contract. The Division of Behavioral Health (DBH) subcontracts with the Department of Public Safety, Division of Alcohol and Tobacco Control for enforcement of the federal Family Smoking Prevention and Tobacco Control Act. DBH uses a Statewide Training and Resource Center (STRC) to provide information, technical assistance, and training to the Missouri's substance abuse prevention workforce. The STRC is also a member of Community Anti-Drug Coalitions of America (CADCA). DBH, in collaboration with the STRC and the Missouri Alliance for Drug Endangered Children, sponsored the 2016 Substance Abuse Prevention Conference attended by about 200 prevention professionals. DBH also provides funding to the Missouri Youth/Adult Alliance (MYAA), a statewide coalition that provides resource materials and education to local community efforts focused on underage drinking.

DBH contracts with 10 community-based Regional Support Centers (RSC) that are state-certified to provide prevention services on alcohol, tobacco, and other drug (ATD) issues. The RSC's are the primary source of training and technical assistance support for over 150 community coalitions located throughout the state. The coalitions are teams of volunteers of community leaders, parents, and youth who seek to address substance abuse in their communities. The RSC's employ prevention specialist that serve as community-level experts to assess community needs, build capacity, develop strategic plans, and implement evidence-based prevention programming. The RSC's provide retailer education on state and federal tobacco regulations to local tobacco retailers and assist the state in compiling a list of tobacco retailers in support of federal Synar requirements, as Missouri does not have tobacco licensure. DBH also provides funding to Partners in Prevention (PIP), Missouri's higher education substance abuse

consortium representing 21 colleges and universities and serving about 161,000 college students. PIP administers the Missouri College Student Health Behavior Survey (MCHBS) which is completed by approximately 9,000 students each school year. The RSC's, PIP, and many community coalitions have been trained on and use SAMHSA's Strategic Prevention Framework planning process. In support of prevention planning at the local level, DBH funds the biennial Missouri Student Survey (MSS) to assess substance use and related behaviors among students in grades 6 through 12.

DBH's School-based Prevention, Intervention, and Resources Initiative (SPIRIT) implements school-based curricula of proven effectiveness for reducing substance use, preventing substance initiation, and reducing violent behavior among children in kindergarten through 12th grade. Age- and grade-appropriate programs are selected from SAMHSA's National Registry of Evidence-based Programs and Practices. SPIRIT currently operates in four sites serving six school districts across the state. These school districts serve high-risk populations characterized by: 1) high percentage of students qualifying for reduced/free lunches, 2) low standardized test scores, 3) high prevalence of substance use, 4) low graduation rates, and/or 5) high rate of juvenile justice referrals. Screening and referral services are provided. In FY 2016, about 5,900 students participated in the SPIRIT program. DBH contracts with the Missouri Institute of Mental Health to conduct an annual evaluation of the SPIRIT program.

DBH also funds other selective prevention services and early intervention activities for designated children, youth, and families. These services involve structured programming and/or a variety of activities including informational sessions and training. Target groups include youth experiencing academic failure and low-income youth and families. Programs are located in Kansas City, St. Louis, Greene County, Branson, Rolla, and the seven-county area in southeastern Missouri known as the "Bootheel". DBH contracts with the Missouri Alliance of Boys and Girls Club sites throughout the state for implementation of SMART Moves (Skills Mastery and Resistance Training) serving over 60,000 youth ages 5-18. DBH contracts with the Leadership Through Education and Advocacy for the Deaf (L.E.A.D.) for the provision of prevention services for deaf and hard of hearing youth. L.E.A.D. conducts the annual Teen Institute for the Deaf attended by approximately 40 youth ages 12 to 17.

In 2010, Missouri established an interagency Statewide Epidemiology Outcomes Workgroup (SEOW) through funding support from SAMHSA. The mission of Missouri's SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and
- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

Missouri's SEOW is chaired by a Research Assistant Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. Membership includes data experts from mental health, social services, public safety, health, education, and the judicial system. DBH's

Research Coordinator and Director of Prevention and Mental Health Promotion are SEOW members.

DBH's Crisis Intervention Team (CIT) training program is a community-based collaboration that trains law enforcement officers and first responders to take appropriate action with individuals having a mental illness or substance abuse crisis. The program provides specialized training under the instructional supervision of behavioral health providers, family advocates, and behavioral health consumer groups. Training provides an overview of mental illness and substance abuse, discussions with consumers and family members, the development of active listening skills and de-escalation techniques, and information on community resources. CIT training seeks to increase the safety of both the officer and the consumer and to divert the consumer from jail settings to behavioral health treatment and/or services.

In 2008, the Missouri Division of Behavioral Health, the Maryland State Department of Health and Mental Hygiene, and the National Council for Community Behavioral Healthcare worked to bring Mental Health First Aid (MHFA), initially developed in Australia, to the United States. MHFA-USA seeks to provide the general public with basic first aid interventions for common behavioral health problems. MHFA is a 12-hour health literacy program that teaches the public how to recognize the signs and symptoms of mental health problems. Over 33,900 individuals have taken the MHFA course in Missouri. A 5-day instructor course is also available for individuals seeking instructor certification. Over 250 individuals have been certified as MHFA instructors in Missouri. A Youth MHFA-USA course has been developed to teach individuals how to help a youth in crisis or experiencing a mental health or substance abuse issue.

Disaster Services

The Department of Mental Health's (DMH) Office of Disaster Services (ODS) conducts planning and development activities to support a coordinated mental health response for Missourians in disaster situations. ODS coordinates efforts with the State Emergency Management Agency (SEMA) and the Department of Health and Senior Services. ODS also develops and administers the FEMA Crisis Counseling Program grant when there is a federal declaration in Missouri. ODS coordinates the DMH Show-Me Response that deploys, in the event of a disaster, volunteers of licensed professionals such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, certified substance abuse counselors, and developmental disability professionals. ODS represents DMH on the Governor's Faith-Based & Community Service Partnership for Disaster Recovery to aid Missourians' recovery plans by developing and implementing a holistic approach to disaster recovery. In January 2012, a child trauma treatment center *Will's Place* opened in Joplin to provide ongoing specialized mental health treatment for children and training for adult responders. Will's Place received a SAMHSA grant that enables the center to be a Category III Community Treatment and Services Center of Excellence to serve a regional four-state area that includes Missouri, Arkansas, Kansas, and Oklahoma.

Administration

The Division of Behavioral Health's (DBH) administration unit includes budgetary/financial analysis and monitoring, grants management, the Customer Information and Management Outcomes and Reporting (CIMOR) Help Desk, and Research and Statistics. In the Research and Statistics unit, DMH's Research Coordinator is also the Drug & Alcohol Services

Information System/Treatment Episode Dataset (DASIS/TEDS) manager and the State Synar Coordinator. Process measures and client outcomes data are generated for program monitoring and federal reporting. DBH produces an annual Status Report on Missouri's Substance Abuse and Mental Health Problems that provides epidemiological profiles of the state, its counties, and planning regions. In FY 2016, DBH published its 22nd edition of the annual status report and, in collaboration with the state epidemiology workgroup, has implemented a web-based querying tool to facilitate use of behavioral health data at the local level.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Assessment of Need

Behavioral Health Data

The Missouri Department of Mental Health (DMH) planning utilizes prevalence data, behavioral health indicators, treatment admissions data, population estimates, needs assessments, and outcomes data. DMH assimilates behavioral health-related data from several national and state surveys. DMH acquires state and sub-state estimates from the National Survey on Drug Use and Health (NSDUH), state estimates from the Youth Risk Behavior Survey (YRBS), state estimates from the Behavior Risk Factor Survey (BRFS), state and county-level data from the Missouri Student Survey (MSS) for grades 6 through 12, and state data collected from 21 of Missouri's universities and colleges using the Missouri College Health Behavior Survey (MCHBS). DMH annually updates prevalence estimates using the most current survey data.

DMH collects an array of behavioral health indicator data, mostly from other state agencies. The indicators include traffic crashes, fatalities, injuries, and DUI arrests; HIV/AIDS cases; hospital and emergency room admissions; impaired births; induced deaths; adult and juvenile arrests; school discipline incidents; out-of-home juvenile placements; methamphetamine lab confiscations; probation, parole, and prison admissions; and drug, DUI, and mental health court enrollments. DMH also collects other indicator data including school dropouts, juvenile status offenses, domestic violence, violent and property crime indices, and unemployment rates. DMH annually assembles the indicators into geographic profiles for Missouri's 114 counties plus the city of St. Louis, service areas, planning regions, and the state.

Substance use and mental health treatment admissions data are retrieved from the DMH Customer Information, Management, Outcomes, and Reporting (CIMOR) system, based on each consumer's county of residence. Information on demographics, substances used, diagnoses, and treatment services are assembled by fiscal year into geographic profiles for the counties, planning regions, service areas, and state. These profiles are included in DMH's annual Status Report on Missouri's Substance Use and Mental Health Problems.

State Epidemiology Outcomes Workgroup

In 2010, Missouri was awarded a State Epidemiology Outcomes Workgroup (SEOW) contract, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The state used this funding to revitalize its SEOW workgroup that had been established under Strategic Prevention Framework State Incentive Grant (2004-2009) to address underage drinking. The mission of Missouri's current SEOW is to:

- Create and implement a systematic process for gathering, reviewing, analyzing, integrating, and monitoring data that will delineate a comprehensive and accurate picture of behavioral health issues in the State and its communities;
- Inform and guide behavioral health prevention policy, program development and evaluation in the State; and

- Disseminate information to State and community agencies, targeted decision-makers, and the general public.

The SEOW is chaired by a Research Assistance Professor at the Missouri Institute for Mental Health – University of Missouri, St. Louis. DMH’s Director of Prevention, Research Coordinator, and Director of Quality Improvement are members of the SEOW.

Name	SEW Position	Title	Agency
Susan Depue	chairperson	Research Assistant Professor	Missouri Institute for Mental Health
Stacy Scott	member	Research Assistant Professor	Missouri Institute for Mental Health
Angie Stuckenschneider	member	Prevention Director	Missouri Department of Mental Health
Christie Lundy	member	Research Coordinator	Missouri Department of Mental Health
Emilia Beckmann	member	Research Analyst	Missouri Department of Mental Health
Jamie Meyers	member	Prevention Specialist	Prevention Consultants of Missouri
Jessica Howard	member	Prevention Specialist	Family Counseling Center, Inc.
Jenny Armbruster	member	Prevention Specialist	National Council on Alcoholism and Drug Abuse
Annie Jensen	member	Prevention Specialist	Southeast Missouri University
Angela Tolman	member	Prevention Specialist	Southeast Missouri Behavioral Health
Vicky Ward	member	Prevention Specialist	Tri-County Mental Health Services
Rikki Barton	member	Prevention Specialist	Community Partnership of the Ozarks

As part of the SAMHSA-funded Partnership for Success II Grant (2015-2020), the SEOW has been responsible for providing data expertise and support to Partnership coalitions in reducing risk factors and promoting protective factors common to alcohol, tobacco, and other drug use, including prescription drug misuse. As part of the broader behavioral health system, the SEOW workgroup continues to assess data gaps, enhance capacity to use behavioral health data, promote data driven decision-making, increase dissemination of data and analyses, promote common data standards, and increase data collaborations.

Overall Need

Serious Emotional Disturbance (Children) and Serious Mental Illness (Adults)

Substate Planning Area	2015 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2016	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	353,439	24,741	5,143	19,598	79.21%
Central	181,121	12,679	2,509	10,170	80.21%
Eastern	479,388	33,558	4,047	29,511	87.94%
Southwest	216,639	15,165	2,442	12,723	83.90%
Southeast	160,889	11,263	2,939	8,324	73.91%
State Total	1,391,476	97,406	17,080	80,326	82.47%

Table 1 FY 2016 Estimated prevalence of childhood serious emotional disorder.

Substate Planning Area	2015 Population Age 18+	Estimated Need (5.4%)	Received Treatment FY 2016	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	1,136,243	61,358	17,486	43,872	71.50%
Central	639,047	34,509	7,338	27,171	78.74%
Eastern	1,640,008	88,561	16,691	71,870	81.15%
Southwest	728,944	39,363	8,329	31,034	78.84%
Southeast	547,954	29,590	11,028	18,562	62.73%
State Total	4,692,196	253,381	60,872	192,509	75.98%

Table 2 FY 2016 Estimated prevalence of adult serious mental illness.

State estimates for serious mental illness (SMI) (adults) and serious emotional disturbances (SED) (children) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Based on these historically reported estimates required for use in the Block Grant State Plan, approximately 5.4 percent of the Missouri adult population has an SMI and 7 percent of Missouri children have an SED. Based on national NSDUH data, the estimated number of adults with SMI in the past year who did not receive mental health treatment in the past year is about 32 percent or an estimated 81,082 Missouri adults with SMI (SAMHSA, 2015). For the remaining 172,299 Missouri adults with SMI who did received some level of mental health treatment, it is not known what portion of these received a sufficient level of care to address their SMI condition. A study by Mark and Buck (2006) examining

characteristics of U.S. youth with SED found that about 44 percent were covered by private insurance, 31 percent were enrolled in Medicaid/Children's Health Insurance Program (CHIP), 11 percent were covered by another unspecified public program, and about 14 were uninsured. It is reasonable to assume that the majority if not the entire uninsured group represents unmet need. It is not known what portion of the private insurance group did not have sufficient coverage for adequate care of the child's SED condition.

As of July 2017, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. The majority of Department of Mental Health consumers with SMI do not have private insurance.

Substance Use Disorder

Substate Planning Area	2015 Population Age 12-17	Estimated Need 4.87%	FY16 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	118,459	5,769	759	5,010	86.84%
Central	60,720	2,957	467	2,490	84.21%
Eastern	164,550	8,014	746	7,268	90.69%
Southwest	74,432	3,625	583	3,042	83.92%
Southeast	55,032	2,680	442	2,238	83.51%
State Total	473,193	23,045	2,997	20,048	87.00%

Table 3 FY 2016 Estimated prevalence of adolescent substance use disorder.

Substate Planning Area	2015 Population Age 18+	Estimated Need 8.26%	FY16 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	1,136,243	93,854	8,027	85,827	91.45%
Central	639,047	52,785	4,935	47,850	90.65%
Eastern	1,640,008	135,465	11,327	124,138	91.64%
Southwest	728,944	60,211	6,349	53,862	89.46%
Southeast	547,954	45,261	5,800	39,461	87.19%
State Total	4,692,196	387,576	36,438	351,138	90.60%

Table 4 FY 2016 Estimated prevalence of adult substance use disorder.

County-level population of persons age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2017). Statewide estimates for substance use disorder treatment need are obtained from the National Household Survey (NSDUH) (SAMHSA, 2016). The difference between estimated need and number served yields the combination of estimated served outside of the state system and unmet need. As of July 2017, it is not known if Missouri will expand its Medicaid program to 138 percent of the federal poverty level. Less than five percent of DMH consumers receiving

substance use disorder treatment in FY 2013 had private health insurance at the time of admission.

Coordination of Primary Care and Behavioral Health Services

Individuals with serious mental illness die 11 to 32 years prematurely from preventable chronic health conditions such as heart disease, diabetes, cancer, pulmonary disease, and stroke (National Institute on Mental Health, 2012). In addition, individuals with co-occurring mental illness and substance use disorders are at greater risk for relapse and tend to have poorer outcomes in comparison to individuals with only a substance use disorder (Compton, W.M., Cottler, L.B., Behn-Abdallah, A., & Spitnagel, E.L., 2003; Hser, Y.I., Evans, E., Teruva, C., Huang, D., & Anglin, M.D., 2007). Expenditures for co-occurring individuals on Medicaid tend to be higher because of not only the substance use and mental illness disorders but also accompanying physical disorders (Clark, R.E., Samnaliev, M., & McGovern, M.P., 2009). The Missouri Department of Mental Health (DMH) has implemented a Health Home model for its Community Mental Health Centers (CMHC) and disease management programs for both serious mental illness and substance use disorders. Under the Health Home model, individuals with serious mental illness served by the CMHC's have monitoring of their health status; coordination of their care including their physical health needs; individualized care planning; and promotion of self-management. For an individual to be eligible for enrollment in Missouri's Health Home, he/she must meet one of the following three conditions:

- 1) have a serious and persistent mental illness,
- 2) have a mental health condition and a substance use disorder, or
- 3) have a mental health condition or a substance use disorder and one other chronic health condition.

DMH's disease management programs target Medicaid-enrolled adults with serious mental illness or substance use disorders and high medical costs who are not currently engaged in behavioral health treatment.

Crisis Intervention

Individuals experiencing a crisis due to a behavioral health condition often visit the emergency room or have contact with law enforcement or other first responders. In 2014, Missouri had over 79,000 emergency room visits in which the primary diagnosis was for a mental illness. In addition, there were roughly 35,000 emergency room visits in which the primary diagnosis was for alcohol and/or drug use (Smith, R. *et al*, 2017). Research suggests that about 7 percent of all police contacts in urban settings involve a person experiencing mental illness (Deane, M. *et al.*, 1999). In a random sample of 500 recent admissions to Missouri's penal institutions, about one-half (48 percent) were assessed with serious functional impairment due to a substance use disorder and 14 percent were under clinical care for a mental illness (Missouri Department of Mental Health, 2015). DMH has implemented several projects: 1) Community Mental Health Liaisons, 2) Emergency Room Enhancements, 3) Crisis Intervention Team (CIT), and 4) Assess Crisis Intervention (ACI) hotlines with the goals of increasing access to treatment and improving individual outcomes.

Substance Abuse Traffic Offenders' Program

Substate Planning Area	FY 2016 Screened due to DWI/DUI
Northwest	4,425
Central	2,722
Eastern	5,278
Southwest	3,041
Southeast	2,009
Other (non-resident)	2,112
State Total*	19,587

Table 5 Number screened due to a DUI arrest.

Missouri's Substance Abuse Traffic Offender Program (SATOP) is a statewide network of community-based education and treatment options for individuals arrested in Missouri for alcohol- and drug-related driving offenses. Completion of SATOP is a requirement by state statute as a condition of license reinstatement resulting from DWI/DUI administrative action. The program incorporates a comprehensive assessment to determine the appropriate level of education and/or clinical treatment services. DMH continues to work to improve the program in order to reduce DWI/DUI recidivism.

Department of Corrections Community Supervised Offenders

Substance Use

Substate Planning Area	FY 2016 Probation and Parole Population	Probation and Parole Need (68%)	FY16 Served	Estimated Unmet Need	Penetration Gap
Northwest	13,052	8,875	3,262	5,613	63.25%
Central	9,147	6,220	2,271	3,949	63.49%
Eastern	28,743	19,545	5,961	13,584	69.50%
Southwest	11,734	7,979	3,226	4,753	59.57%
Southeast	15,697	10,674	3,586	7,088	66.40%
State Total	78,373	53,293	18,306	34,987	65.65%

Table 6 Estimated need for substance use treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2016 was obtained from the Missouri Department of Corrections (DOC). Estimated need for substance use treatment was determined from the DOC Substance Abuse Classification Assessment (SACA). Most individuals receive an assessment when they enter prison and when they start community supervision. Number served in the publicly-funded system for FY 2016 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference

between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment.

Mental Illness

Substate Planning Area	FY 2016 Probation and Parole Population	Probation and Parole Need (17%)	FY16 Served	Estimated Unmet Need	Penetration Gap
Northwest	13,052	2,219	951	1,268	57.14%
Central	9,147	1,555	690	865	55.63%
Eastern	28,743	4,886	1,518	3,368	68.93%
Southwest	11,734	1,995	793	1,202	60.25%
Southeast	15,697	2,668	1,299	1,369	51.31%
State Total	78,373	13,323	5,251	8,072	60.59%

Table 7 Estimated need for serious mental illness treatment among parole and probation offenders.

The number of individuals on parole or probation for FY 2016 was obtained from the Missouri Department of Corrections (DOC). Estimated need for mental illness treatment was determined from the mental health needs score. Number served in the publicly funded system for FY 2016 was obtained from the Missouri Department of Mental Health billing system. Estimated unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment.

Tobacco Prevention / Cessation

Past Month Cigarette Use for Selected Groups	Missouri	U.S.
Youth Age 12-17	9.28%	6.50%
Young Adults Age 18-25	44.22%	34.02%
Older Adults Age 26+	31.14%	25.14%

Table 8 Prevalence of Current Cigarette Use (SAMHSA, 2017)

Estimates of past month cigarette use were obtained from the National Household Survey on Drug Use and Health (SAMHSA, 2017). Prevalence of cigarette use for Missouri tends to be higher than that for the U.S.

Research has shown that higher merchant compliance with tobacco control laws predicts lower levels of youth smoking (DiFranza, Savageau, & Fletcher, 2009). The Missouri Department of Mental Health - Division of Behavioral Health (DBH) is the state agency that oversees the state's federal Synar requirements and partners with the Department of Public Safety – Division of Alcohol and Tobacco Control for tobacco control efforts. Federal Synar regulations require all states to maintain a retailer non-compliance rate of no more than 20 percent (42 U.S.C. 300x-26 and 45 C.F.R. 96.130). Since 1996, DBH is charged with overseeing

the Synar requirements in Missouri, conducting the annual Synar survey, and implementing tobacco prevention activities as it relates to the sale of tobacco products to minors. A state that fails to comply with the federal Synar requirements is at risk for losing Substance Abuse Prevention and Treatment Block Grant funding.

Recovery Support Services

Substance Use

Research has shown that, for many individuals, recovery coaching, 12-step programs, spirituality, and social and community supports play an important role in maintaining long-term recovery from substance addiction (SAMHSA, 2009). DBH funds peer support services for individuals in substance use treatment. These services are face-to-face services or group services with a rehabilitation and recovery focus. In FY 2016, 2,085 individuals in substance use treatment received peer support services.

Serious Mental Illness

For the provision of behavioral healthcare to individuals with severe mental illness, research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the “difficult-to-engage” clients, reducing hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among clients using those services (Rogers *et al.*, 2007). DMH funds five drop-in centers: two in St. Louis, two in Kansas City, and one in Springfield. DMH’s five Warm (non-crisis) Lines offer safe, confidential telephone support by peers when an individual with a mental illness or family member needs information, referral, or to talk to someone.

Certified Missouri Peer Specialist training began in 2008 in Missouri. After researching peer support training curricula, the Comprehensive Psychiatric Services State Advisory Council (CPS/SAC) made the recommendation for the Appalachian Consulting Group “Georgia Model” which was subsequently adopted by the Division of Behavioral Health. The Department of Mental Health (DMH) is moving the mental health system to a wellness model that empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports. One primary strategy in transforming the system is to recognize the power of consumer as providers. Recognizing consumers as providers is taking root in the mental health system. Emerging evidence supports the need for peer support services as a cost-effective and complementary adjunct to professional mental health services and supports. Peer support services can move the system to focus less on illness and disability and more on wellness. To accomplish this goal, Missouri has provided equal weight to expertise gained through the “lived experience” as is done with any other credential or

knowledge base. A Peer Specialist can share lived experiences of recovery, share and support the use of recovery tools, and model successful recovery behaviors. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment. Additionally, Peer Specialists can help consumers connect with other consumers and with their community at large.

With oversight of the CPS/SAC, the week-long training has been conducted by trained individuals with lived experience of recovery. To date, 298 individuals have reached the goal of Certified Missouri Peer Specialist (CMPS) status. CMPSs are employed around the state providing services in community mental health centers, consumer operated service programs (Drop In Centers and Warm Lines), the Veteran's Administration, substance use residential and outpatient providers, as well as five of our state operated psychiatric facilities. The Medicaid reimbursement rate is comparable to that of a Community Support Worker and continues to be utilized among Missouri providers.

Medication Assisted Treatment for Addiction

Substate Planning Area	FY 2016 Number Served who Had an Alcohol and/or Opiate Use Disorder	FY 2016 Number who Received MAT Services	% Received MAT Services
Northwest	6,000	741	12.35%
Central	3,760	221	5.88%
Eastern	9,544	2,385	24.99%
Southwest	4,377	353	8.06%
Southeast	4,151	473	11.39%
State Total	27,832	4,173	14.99%

Table 9 Number served in state system with an Opioid or alcohol use disorder identified as the primary, secondary, or tertiary substance use disorder and the number who received MAT services including methadone, Vivitrol, naltrexone, buprenorphine/Suboxone, Antabuse, and acamprosate.

Medication assisted treatment (MAT) is the use of medications, in combination with psychosocial counseling, to support treatment and recovery from substance use disorders. DMH fully supports the use of evidence-based practices in substance use treatment, which includes MAT. DMH funds four Opioid treatment programs that are certified to provide methadone maintenance treatment. Two agencies are located in St. Louis, and two are located in Kansas City. In addition, DMH has been introducing new medications into its non-Opioid treatment programs since 2006 as part of a Robert Wood Johnson Advancing Recovery Grant. Medication services were added to treatment contracts in 2007. In 2010, Missouri began credentialing for a MAT specialty. DMH continues to work to integrate MAT into addition treatment where clinically appropriate. The National Quality Forum recommendations state that

pharmacotherapy should be made available to all adult patients diagnosed with an alcohol or Opioid dependence if no medical contradictions are applicable (National Quality Forum, 2007).

Community Advocacy and Education

Substance Use

Approximately 419,000 Missourians have a substance use disorder (SAMHSA, 2015). Alcohol, tobacco, and other drug (ATOD) use are impacted by social acceptability including community laws and norms favorable toward use as well as by availability of the substances. Missouri's approximately 160 community coalitions; the 11 regional support centers; and Missouri's higher education substance use consortium, Partnerships in Prevention (PIP) work to change community norms, policy, and substance availability in support of creating healthy, safe communities. The Regional Support Centers, in collaboration with the community coalitions, develop, implement, and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.

	Missouri	U.S.
Nonmedical Use of Pain Relievers in Past Year, Age 12+	4.71%	4.51%
Alcohol Use in Past Month, Age 12-17	12.40%	12.23%
Tobacco Use in Past Month, Age 12+	33.52%	26.10%

Table 10 Estimates of Substance Use (SAMHSA, 2015)

Substate Planning Area	2015 Population Age 12-17	FY 2016 Heroin Admissions	Heroin Treatment Admissions per 10,000 Population
Northwest	1,254,702	360	2.9
Central	699,767	314	4.5
Eastern	1,804,558	3,362	18.6
Southwest	803,376	218	2.7
Southeast	602,986	411	6.8
State Total	5,165,389	4,665	9.0

Table 11 Rates of heroin-related admissions to substance use treatment in FY 2016 (Smith *et al.*, 2017).

Some issues facing Missouri's communities include: 1) methamphetamine imported from out of state; 2) prescription drug misuse; 3) underage drinking, and 4) continued availability and use of heroin in Eastern Missouri. In addition, the statewide use of tobacco products tends to be higher than that for the country as a whole. Approximately 4.71% of Missourians age 12 or older engage in nonmedical use of pain relievers in the past year (SAMHSA, 2015). In FY 2015, Eastern Missouri had a higher rate of heroin-related admissions to substance use treatment compared to that of other regions of the state (Smith *et al.*, 2016).

Current use of tobacco by Missourians age 12 or older is 33.52 percent – higher than that for the United States (26.10%) (SAMHSA, 2015).

Mental Illness

	Age 12-17		Age 18+	
	Missouri	U.S.	Missouri	U.S.
Serious Mental Illness in the Past Year			4.67%	4.14%
Had Serious Thoughts of Suicide in Past Year			4.05%	3.89%
Had at Least One Major Depressive Episode in the Past Year	9.91%	9.86%	7.35%	6.77%

Table 12 Prevalence of Mental Illness (SAMHSA, 2015).

Behavioral health issues such as substance addiction and mental illness often carry a stigma that prevents individuals from seeking help and others from providing help. Of those Missourians who experience serious psychological distress in the past year, an estimated 50 percent do not receive any mental health treatment (SAMHSA, 2012f). Research has shown that Mental Health First Aid, a public education program designed for the general public in appropriately responding to behavioral health issues, is associated with increased knowledge of behavioral health disorders, less stigmatization, and greater confidence to provide assistance (Kitchener, J.A., 2004; Kitchener, B.A. & Jorm, A.F., 2004). The Missouri Department of Mental Health has partnered with the Maryland Department of Health and Mental Hygiene and the National Council for Community Behavioral Healthcare to implement Mental Health First Aid USA, modeled after a program developed in Australia. Missouri is piloting a second version of Mental Health First Aid for adults who work with young people – Mental Health First Aid for Youth.

School-Based Behavioral Health Education

	Missouri	United States
Past Month Illicit Drug Use	9.5%	9.2%
Past Month Binge Alcohol Use	15.3%	14.7%
Past Month Cigarette Use	8.6%	6.1%
Past Year Major Depressive Episode	9.9%	9.9%

Table 13 Behavioral Health Measures: Age 12 - 17 (SAMHSA, 2015).

An estimated 14.3 percent of Missouri's youth in grades 6 through 12 report using alcohol in the past 30 days. In addition, 7.0 percent and 10.6 percent reported using marijuana and electronic cigarettes, respectively, in the past month (Depue, S. & et al., 2015). Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) implements evidence-based programming to delay the onset of substance use and decrease the use of substances, improve overall school performance, and reduce incidents of violence. Age- and grade-

appropriate curricula are taught. Screening and referral services are provided as needed. The program receives an annual evaluation by the Missouri Institute for Mental Health, University of Missouri-St. Louis.

Prescription Drug Overdose

Substate Planning Area	2015 Population	Opioid Deaths (2001-2015) Rates per 100,000 persons
Northwest	1,489,682	4.3
Central	820,168	3.4
Eastern	2,119,396	10.8
Southwest	945,583	4.5
Southeast	708,843	4.3
State Total	6,083,672	6.5

Table 14 Rates of opioid deaths per 100,000 persons.

Missouri has about 1,000 drug-induced deaths each year (DMH, 2016). Over one-half of those involve opioids (CDC, 2016). An estimated 4.02 percent or 206,300 Missourians report nonmedical use of pain relievers in the past year. The percentage is comparable to that of the country as a whole (SAMHSA, 2016). In 2012, Missouri ranked 14th when comparing the rates of prescribing opioid pain relievers among states. Missouri had 94.5 opioid pain reliever prescriptions per 100 persons – compared to the rate of 82.5 for the United States (Paulozzi *et al.*, 2014). In July 2017, Missouri’s governor issued an executive order creating a Prescription Drug Monitoring Program. Missouri has received a five-year grant from SAMHSA to increase overdose education and the distribution of naloxone to first responders, health care providers, and other members of the community.

Evidence-based Behavioral Health Practices

The Department of Mental Health (DMH) supports implementation of programs and practices that have proven effectiveness in reducing the impact of behavioral health disorders on individuals and families in Missouri. Missouri has implemented the following evidence-based practices in the treatment of serious mental illness (SMI):

- Integrated treatment for co-occurring mental illness and substance use disorders,
- Supported employment,
- Illness management and recovery,
- Assertive community treatment, and
- Consumer-operated services.

Individuals with co-occurring SMI and substance use disorders tend to have poorer outcomes when served in traditional treatment programs where each disorder is treated by a separate team of providers (McGovern, M.P., 2006). The evidence-based treatment model of care for persons with co-occurring disorders that is recommended by SAMHSA is the Integrated Treatment for Co-Occurring Disorders (ITCOD). In the ITDOC model persons receive

coordinated, integrated treatment by a single multidisciplinary team including trained specialists in co-occurring disorders. Missouri has 20 ITCOD programs operating in 32 locations. Missouri has Medicaid approved billing codes for co-occurring individual counseling, group education, group counseling, and a supplemental individual assessment for substance use disorders. DMH monitors fidelity to the SAMHSA tool kit.

Supported employment programs have been shown to be more effective than traditional vocational programs in gaining competitive employment, earning more income, and working more days for individuals with SMI (Bond, G.R. *et al.*, 2008; Crowther, R.E. *et al.*, 2001). Missouri has seven supported employment programs. The State's programs have received technical assistance and fidelity training from the Dartmouth Psychiatric Research Center through a grant from Johnson & Johnson. Providers collaborate with the Division of Vocational Rehabilitation (VR) vendors to offer supported employment services to ensure that:

- Eligibility is based on consumer choice;
- Supported employment is integrated with treatment;
- Competitive employment is the goal;
- Job search starts soon after the consumer expresses interest in working;
- Follow-along supports are continuous; and
- Consumer preferences are recognized.

Fidelity is monitored for the Individualized Placement Support (IPS) Supported Employment model.

Illness management recovery strategies have been shown to increase the individual's knowledge of their condition, aid in medication compliance, and reduce the occurrence and severity of symptom relapse (Mueser, K.T. *et al.*, 2002). DMH, in collaboration with the State Medicaid authority, has established an enhanced rate for Psychosocial Rehabilitation. Twenty community mental health centers provide these services that focus on health, wellness, and recovery. Fidelity to this evidence-based practice is not monitored.

Assertive Community Treatment (ACT) has been shown to reduce hospitalizations for individuals with severe mental illness (Phillips, S.D. *et al.*, 2001). In Missouri, ACT services are made available to adults with serious and persistent mental illness who: 1) are high users of inpatient beds, 2) may have a co-occurring substance use disorder, 3) have involvement with the criminal justice system, and 4) are homeless. DMH funds six ACT programs. Missouri has obtained technical assistance from the ACT Center of Indiana and continues to monitor fidelity of its implementation.

Research has shown that peer support staff function at least as well as non-peer staff in roles such as case managers, rehabilitation staff, and outreach workers. Moreover, peer services tend to generate better outcomes in engaging the "difficult-to-engage" clients, reducing

hospitalizations for clients, and in decreasing substance use among co-occurring clients (Davidson, L., Bellamy, C., Guy, K., & Miller, R., 2012). Findings from the SAMHSA Consumer-Operated Service Program (COSP) Multisite Research Initiative showed that adding peer support services or programs to traditional mental health programs was positively associated with increased personal empowerment among clients using those services (Rogers *et al.*, 2007). DMH funds 10 COSP programs. Fidelity to the COSP is monitored using the SAMHSA tool kit.

In addition to the evidence based practices listed above, DMH also funds Dialectical Behavior Therapy (DBT), a cognitive-behavioral treatment initially developed to treat individuals with borderline personality disorder (BPD) but has also been found to be effective for persons with other diagnoses. Several studies have shown that DBT had better outcomes in the treatment of BPD compared to treatment as usual on measures of anger, parasuicidality, and mental health (Stoffers, J.M. *et al.*, 2012). Introductory and advanced DBT training has been made available statewide. DMH has partnered with the University of Missouri Psychiatric Center to produce an online training in communication strategies. DMH also supports a DBT website (www.dbtmo.org) to provide information on DBT and the DBT certification process.

Substance Use-Related Services for IV Drug Users

Substate Planning Area	2015 Population Age 20+	Estimated IVDU Need	IVDU FY 2016 Served	Estimated IVDU Need but Not Receive	Penetration Gap
Northwest	1,100,611	5,283	1,595	3,688	69.81%
Central	610,283	2,929	1,155	1,774	60.57%
Eastern	1,589,361	9,854	3,873	5,981	60.70%
Southwest	704,015	3,379	2,037	1,342	39.72%
Southeast	530,696	2,547	1,688	859	33.73%
State Total	4,534,966	23,993	10,348	13,645	56.87%

Table 15 Estimates of prevalence and need for the treatment of IV drug use.

In the past, the number of intravenous drug users (IVDU) was estimated at 0.19 percent of the population aged 12 or older from NSDUH national-level data. Based on 1) the number of IV drug users served and the number on wait lists and given that 2) NSDUH excludes some populations with higher rates of drug use such as incarcerated individuals, homeless, hospitalized patients, and college dormitory students, the NSDUH estimate was believed to generate estimates for Missouri that seriously underestimates the number of IV drug users in the state. Research from Brady *et al.* estimated the prevalence of IV drug users in the U.S. and in 76 metropolitan statistical areas (MSA) (Brady, J.E. *et al.*, 2008). Brady's estimates for IV drug users in the Kansas City and St. Louis MSA's exceeded that generated from the NSDUH data by a factor of 2.7 and 3.4, respectively. Brady's prevalence rate for Kansas City MSA and St. Louis MSA was applied to the populations of Northwest and Eastern regions. The remaining regions

were assumed to have a similar rate as that of Northwest region and a corresponding estimate was generated for the remaining regions. The number of IVDU's served by substate region was obtained from the publicly-funded system (Missouri Department of Mental Health, 2017). The estimated number for unmet need is the difference between number in need and number served. Penetration gap is that proportion of estimated need that did not received treatment. In Missouri, methamphetamine IV drug use is prevalent throughout the rural areas of the state but is particularly notable in Southwest, Southeast, and Northwest Regions. Heroin and other Opioid IV drug use are highly concentrated in Eastern Region impacting both urban and rural locations. Seventy-three percent of the state's heroin-related deaths are reported from Eastern Region (Missouri Department of Health and Senior Services, 2016).

Substance Use-Related Services for Pregnant Women and Women with Dependent Children

An estimated 8 percent of pregnant women have a substance use disorder. In general, an estimated 5.7 percent of women have a substance use disorder (SAMHSA, 2016).

Substate Planning Area	2015 Female Population Age 12+	Women Need (5.7%)	Women FY 2016 Served	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	643,527	36,681	3,353	33,328	90.86%
Central	349,873	19,943	2,108	17,835	89.43%
Eastern	941,737	53,679	4,667	49,012	91.31%
Southwest	411,487	23,455	2,753	20,702	88.26%
Southeast	303,475	17,298	2,536	14,762	85.34%
State Total	2,650,099	151,056	15,417	135,639	89.79%

Table 16 Prevalence of substance use problems among women (SAMHSA, 2016).

County-level population of females age 12 or older was obtained from the Missouri Census Data Center and aggregated to the substate areas (Missouri Census Data Center, 2016). The estimated percent in need of treatment (5.7%) is obtained from the National Household Survey on Drug Use and Health (NSDUH) dataset (2014) for females. The number served in the state system in FY 2016 was obtained from the Department of Mental Health information system. The difference between estimated need and number served is a combination of number served outside of the state system and unmet need.

Mental Health Services for Transition-Aged Youth and Young Adults

Substate Planning Area	2015 Population 16-17	2015 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (5%)	Total Estimated Need
Northwest	39,460	158,857	2,762	7,943	10,705

Substate Planning Area	2015 Population 16-17	2015 Population 18-25	Estimated Need, Age 16-17 (7%)	Estimated Need, Age 18-25 (5%)	Total Estimated Need
Central	20,361	116,266	1,425	5,813	7,239
Eastern	55,660	216,762	3,896	10,838	14,734
Southwest	25,009	107,815	1,751	5,391	7,141
Southeast	18,599	73,732	1,302	3,687	4,989
State Total	159,089	673,432	11,136	33,672	44,808

Table 17 Estimated need for mental health services among transition age youth and young adults.

Individuals who are transitioning into adulthood and have or develop a serious mental illness face unique challenges. Compared to the general population, these individuals tend to have increased difficulty in reaching developmental milestones such as graduating from high school, gaining employment, securing stable housing, and developing and sustaining meaningful relationships. In a study by the U.S. Government Accounting Office (GAO) (2008), young adults age 18 to 26 with SMI graduated from high school at a lower rate compared to those without SMI (64% vs. 83%). For young adults who were receiving disability payments from SSI or DI, the high school graduation rate was even lower at 52%. Transition-age youth are more likely to become involved with the juvenile justice system and are at increased risk for substance use (Gilmer, T. P. *et al.*, 2012). Although SMI may develop earlier than age 16, it is not uncommon for the diagnosis to be made during the late teens and early twenties. As such, individuals and their families may be inexperienced at navigating multiple systems of care and programs. Adult and youth programs often have differing eligibility requirements and service mix that can cause disruptions in continuity of care once an individual reaches age 18. In looking at mental health service utilization in the U.S., Pottick *et al.* (2008) found that service utilization fell by almost 50 percent at the age of emancipation. Adult programs may be more tailored to the needs of older adults which may cause young adults to feel disenfranchised and result in treatment drop-out (GAO, 2008). In FY 2016, DMH provided community-based mental health services to 11,042 transition-aged youth and young adults.

Behavioral Healthcare Services for Children

Substate Planning Area	2015 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2016	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	353,439	24,741	5,143	19,598	79.21%
Central	181,121	12,679	2,509	10,170	80.21%

Substate Planning Area	2015 Population Age 0-17	Estimated Need (7%)	Received Treatment FY 2016	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Eastern	479,388	33,558	4,047	29,511	87.94%
Southwest	216,639	15,165	2,442	12,723	83.90%
Southeast	160,889	11,263	2,939	8,324	73.91%
State Total	1,391,476	97,406	17,080	80,326	82.47%

Table 18 FY 2016 Estimated prevalence of childhood serious emotional disorder.

Substate Planning Area	2015 Population Age 12-17	Estimated Need 4.87%	Received Treatment FY 2016	Estimated Served Outside of State System + Unmet Need	Percent of Need Not Served by State System
Northwest	118,459	5,769	759	5,010	86.84%
Central	60,720	2,957	467	2,490	84.21%
Eastern	164,550	8,014	746	7,268	90.69%
Southwest	74,432	3,625	583	3,042	83.92%
Southeast	55,032	2,680	442	2,238	83.51%
State Total	473,193	23,045	2,997	20,048	87.00%

Table 19 FY 2016 Estimated prevalence of adolescent substance use disorder.

Children with behavioral health issues face challenges in many aspects of their daily lives. Missouri supports the systems of care approach that recognizes the importance of family, school, and community and in which services are provided through a comprehensive, seamless system. Both substance use disorder and mental health services for children are coordinated under the Division of Behavioral Health (DBH) Director of Children's Services. Community Psychiatric Rehabilitation (CPR) provides a range of essential mental health services to children and youth with serious emotional disturbances. The Comprehensive Substance Treatment and Rehabilitation (CSTAR) Adolescent program offers a full continuum of services for youth age 12 to 17 with substance use disorders.

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Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-

identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

The Department of Mental Health's information system is used to collect demographic, programmatic, and encounter data on clients receiving publicly funded substance use and mental health treatment. Missouri is able to report at the provider, program, and client level.

2. **Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).**

The Department of Mental Health's information system which is used to collect data for TEDS and URS is specific to substance use and mental health. It is not part of a larger data system.

3. **Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?**

CAHPS_HEDIS: No

NQF-0104: No

NQF-1364/1365: No

Percentage of Adults with Serious Thoughts of Suicide in the Past Year: From NSDUH

NQF-0710: No

NQF-0028: No

NQF-2602: No

NQF-2603: No

NQF-2605: Only on Health Home participants – not for all mental health and substance use clients

Reduced Tobacco Use: From NSDUH

NQF-2152: No

Underage Drinking: From NSDUH

Prescription Drug Misuse (Treatment): At discharge, from TEDS

Prescription Drug Misuse (Prevention): From NSDUH

Marijuana Use (Treatment): At discharge, from TEDS

Marijuana Use (Prevention): From NSDUH

Employment (Treatment): From TEDS and URS

Employment (Prevention): From NSDUH

Education (Treatment): No

Education (Prevention): No

Criminal Behavior: From TEDS and URS

Criminal Behavior (DUI): Yes, from Department of Public Safety

Stable Housing: From TEDS and URS

Homelessness: From TEDS and URS

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Significant changes would be required of the state's and providers' information systems and business processes. New assessments may require additional compensation to the providers. Without additional funding, fewer clients being served in treatment would most likely result.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Coordination of Primary Care and Behavioral Health Services

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Coordinate consumers' primary and behavioral healthcare in order to improve consumer health and reduce medical costs.

Objective:

Increase participation in programs that coordinate consumers' primary and behavioral healthcare

Strategies to attain the objective:

- 1) Continue to coordinate preventive and primary care for Health Home participants
- 2) Continue outreach to Medicaid-enrolled adults who 1) have a substance use disorder or serious mental illness, 2) have high annual healthcare costs, and 3) are not currently enrolled in behavioral health treatment
- 3) Contract with the Missouri Institute for Mental Health for ongoing evaluation of Missouri's Health Home programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of participants in Health Homes per fiscal year

Baseline Measurement: 35,755

First-year target/outcome measurement: at least 37,000

Second-year target/outcome measurement: at least 40,000

Data Source:

The number of Health Home participants is determined from a Per Member Per Month (PMPM) data file submitted to DMH from the Missouri Medicaid agency MO Healthnet on a monthly basis. These are individuals who participated at any time during the specified fiscal year.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of participants in DM 3700 per fiscal year

Baseline Measurement: 3,636

First-year target/outcome measurement: at least 3,550

Second-year target/outcome measurement: at least 3,550

Data Source:

Numbers of ADA DM and DM 3700 participants are tracked in the DMH information system. A participant in ADA DM is defined as a consumer who is listed on the ADA Disease Management master list and who has an open ADA episode of care during the specified fiscal year. A participant in the DM 3700 is defined as a consumer who is listed on the DM 3700 master list and who has an open CPS episode of care during the specified fiscal year.

Description of Data:**Data issues/caveats that affect outcome measures::**

Indicator #: 3

Indicator: Number of participants in ADA Disease Management per fiscal year

Baseline Measurement: 806

First-year target/outcome measurement: at least 750

Second-year target/outcome measurement: at least 750

Data Source:

Numbers of ADA DM and DM 3700 participants are tracked in the DMH information system. A participant in ADA DM is defined as a consumer who is listed on the ADA Disease Management master list and who has an open ADA episode of care during the specified fiscal year. A participant in the DM 3700 is defined as a consumer who is listed on the DM 3700 master list and who has an open CPS episode of care during the specified fiscal year.

Description of Data:**Data issues/caveats that affect outcome measures::**

Priority #: 2

Priority Area: Crisis Intervention

Priority Type: SAT, MHS

Population(s): SMI, SED

Goal of the priority area:

Promote safety and emotional stability, minimize further deterioration in mental state, increase access to treatment and support services, and improve individual outcomes for individuals in behavioral health crisis; better utilize limited criminal justice and healthcare resources by linking individuals needing behavioral healthcare services to those services.

Objective:

Increase linkage and coordination of care for individuals experiencing a behavioral health crisis

Strategies to attain the objective:

- 1) Identify and address structural barriers, miscommunications, and consistent patterns that reduce access to behavioral healthcare services.
- 2) Provide behavioral health expertise to law enforcement, court personnel, and primary healthcare staff in order to more effectively respond to behavioral health crises.
- 3) Advocate for and engage individuals in crisis in behavioral health treatment and support services.
- 4) Provide immediate person-centered interventions to individuals in behavioral health crisis and facilitate timely access to services and supports.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of referrals to the CMHLs per fiscal year

Baseline Measurement: 8,189

First-year target/outcome measurement: at least 8,000

Second-year target/outcome measurement: at least 8,000

Data Source:

Number of law enforcement officers trained in CIT, number of CMHL contacts, the number served in the ERE project are tracked and

reported by the Coalition for Behavioral Healthcare.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number served in the ERE project per fiscal year

Baseline Measurement: 1,329

First-year target/outcome measurement: at least 1,200

Second-year target/outcome measurement: at least 1,200

Data Source:

Number of law enforcement officers trained in CIT, number of CMHL contacts, the number served in the ERE project are tracked and reported by the Coalition for Behavioral Healthcare.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of new law enforcement officers trained in CIT per fiscal year

Baseline Measurement: 800

First-year target/outcome measurement: at least 600

Second-year target/outcome measurement: at least 600

Data Source:

Number of new law enforcement officers trained in CIT is tracked and reported by the CIT Coalition.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Number of ACI calls per fiscal year

Baseline Measurement: 83,985

First-year target/outcome measurement: at least 82,000

Second-year target/outcome measurement: at least 82,000

Data Source:

Number of ACI calls is tracked and reported by the contracted agencies on a quarterly basis.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 3
Priority Area: Substance Abuse Traffic Offenders' Program (SATOP)
Priority Type: SAT
Population(s): Other (Criminal/Juvenile Justice)

Goal of the priority area:

Reduce DWI recidivism and initiate treatment services for those with substance use disorder

Objective:

Improve screening and referral processes

Strategies to attain the objective:

- 1) Continue program oversight to ensure adherence to standards of care
- 2) Increase use of evidence-based practices

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Implement an interactive journal for the Weekend Intervention Program (WIP)
Baseline Measurement: N/A
First-year target/outcome measurement: In progress
Second-year target/outcome measurement: Implemented

Data Source:

Implementation of interactive journal in WIP program monitored by SATOP Director.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 4
Priority Area: Department of Corrections Community Supervised Offenders
Priority Type: SAT, MHS
Population(s): SMI, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Improve access to clinically appropriate services

Objective:

Coordinate with the Department of Corrections to improve access to treatment

Strategies to attain the objective:

- 1) Monitor and target technical assistance to Probation and Parole Officers and treatment providers on the prioritization process for offenders needing substance use disorder treatment in order to facilitate rapid assessment and treatment initiation
- 2) Maintain Memorandum of Understandings (MOU) with the Department of Corrections for coordination of behavioral health treatment services
- 3) Continue the CMHT – Community Mental Health Treatment (mental illness) and MH4 (severe mental illness) programs
- 4) Continue to participate on the DOC Oversight Committee

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Current MOU's between DMH and DOC

Baseline Measurement: yes

First-year target/outcome measurement: yes

Second-year target/outcome measurement: yes

Data Source:

MOU documentation is maintained by the DMH contracts unit.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Implement revised high risk referral form for SUD treatment

Baseline Measurement: N/A

First-year target/outcome measurement: in process

Second-year target/outcome measurement: implemented

Data Source:

Implementation of high risk referral form monitored by the DBH treatment unit.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Tobacco Prevention / Cessation

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Reduce tobacco initiation and promote tobacco cessation among vulnerable populations

Objective:

Provide education and supports to vulnerable populations and Missouri tobacco retailers

Strategies to attain the objective:

- 1) Support provider training in tobacco cessation with proven effectiveness
- 2) Promote the inclusion of tobacco cessation in the consumer's behavioral health treatment plan
- 3) Support tobacco cessation on Missouri's college campuses
- 4) Ensure the provision of tobacco enforcement and merchant education:
 - a. Continue contracting with the Food and Drug Administration for the enforcement of federal tobacco control laws
 - b. Maintain a Memorandum of Agreement with the Division of Alcohol and Tobacco Control for state and federal enforcement of tobacco control laws
 - c. Conduct a merchant education visit to every tobacco retailer in the state

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Synar noncompliance rate is less than 20 percent

Baseline Measurement: yes

First-year target/outcome measurement: yes

Second-year target/outcome measurement: yes

Data Source:

Synar rate is determined from annual Synar survey. For FY 2018, this will be completed by October 1, 2018. For FY 2019, this will be completed by October 1, 2019.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of tobacco retailers visited and provided with retailer educational materials per fiscal year

Baseline Measurement: 5,477

First-year target/outcome measurement: at least 5,200

Second-year target/outcome measurement: at least 5,200

Data Source:

Number of tobacco retailers visited and provided educational materials is documented by prevention agencies, entered into a database by DMH staff, and reported in the State's Annual Synar Report.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of Tobacco Treatment Specialists per fiscal year

Baseline Measurement: 29

First-year target/outcome measurement: at least 25

Second-year target/outcome measurement: at least 25

Data Source:

Number of Tobacco Treatment Specialists is tracked by prevention staff.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 6

Priority Area: Recovery Support Services

Priority Type: SAT, MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Rural, Criminal/Juvenile Justice, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Provide support services to promote sustained recovery from behavioral health disorders

Objective:

Develop infrastructure to support recovery, wellness, and community inclusion

Strategies to attain the objective:

- 1) Continue the five Drop-In Centers and five Peer Support Phone Lines for persons with mental illness
- 2) Maintain a housing unit to administer the Shelter Plus Care grants to provide housing assistance to long-term DMH consumers
- 3) Promote use of IPS Supported Employment

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of contracts for Consumer Operated Service Programs (e.g. Drop-In Centers and Peer Support Warm Lines) for persons with mental illness per fiscal year

Baseline Measurement: 10

First-year target/outcome measurement: 10

Second-year target/outcome measurement: 10

Data Source:

Contracts are maintained by the DMH Contracts Unit.

Description of Data:**Data issues/caveats that affect outcome measures::**

Indicator #: 2

Indicator: Number of IPS SE programs per fiscal year

Baseline Measurement: 13

First-year target/outcome measurement: 13

Second-year target/outcome measurement: 14

Data Source:

The number of IPS Supported Employment programs is tracked by DMH staff.

Description of Data:**Data issues/caveats that affect outcome measures::**

Indicator #: 3

Indicator: Number of families receiving family support per fiscal year

Baseline Measurement: 922

First-year target/outcome measurement: at least 900

Second-year target/outcome measurement: at least 900

Data Source:

The number of Family Support trainings is tracked by the Children's Services Unit.

Description of Data:**Data issues/caveats that affect outcome measures::**

Indicator #: 4

Indicator: Create Family Support Provider website to centralize information, resources, training opportunities, and networking activities.

Baseline Measurement: N/A

First-year target/outcome measurement: In progress

Second-year target/outcome measurement: Completed

Data Source:

Progress on website will be monitored by Children's Unit.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 7

Priority Area: Medication Assisted Treatment (MAT) for Substance Use Disorders

Priority Type: SAT

Population(s): PWWDC, PWID, Other (Rural, Criminal/Juvenile Justice, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

To further integrate medication therapy into the substance use disorder treatment service delivery system

Objective:

Promote use of MAT

Strategies to attain the objective:

- 1) Monitor utilization of MAT by provider and provide technical assistance as needed
- 2) Increase utilization of different MAT medications at a given treatment provider

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of consumers receiving MAT per fiscal year

Baseline Measurement: 5,106

First-year target/outcome measurement: at least 5,000

Second-year target/outcome measurement: at least 5,000

Data Source:

Number of consumers receiving medication assisted treatment including use of methadone, Vivitrol, naltrexone, buprenorphine/Suboxone/Subsolv, Antabuse, Zubsolv, Bunavail, and acamprosate (and any future FDA-approved MAT medication) is determined from medication billings to the DMH information system and Medicaid Claims, excluding billings occurring while in detox.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 8

Priority Area: Community Advocacy and Education

Priority Type: SAP

Population(s): Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Create positive community norms; policy change; promote mental wellness; and reduce alcohol, tobacco, and other drug availability in Missouri's communities

Objective:

Strengthen Missouri's prevention network

Strategies to attain the objective:

- 1) Build state and community capacity by fostering strong partnerships and identifying new opportunities for collaboration
- 2) Further data capacity in support of data-driven strategic planning to include the continuation of the Missouri Study Survey and the Behavioral Health web tool
- 3) Fund evidence-based programming to prevent substance use and bullying among high-risk youth
- 4) Continue the education initiative in Eastern Missouri to address heroin and other opiate drug use

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of heroin and other opiate drug use trainings and education activities per fiscal year

Baseline Measurement: 101

First-year target/outcome measurement: at least 80

Second-year target/outcome measurement: at least 80

Data Source:

Number of heroin education activities is tracked and reported by the Eastern Regional Support Center.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of high-risk youth served in prevention programs per fiscal year

Baseline Measurement: 6,306

First-year target/outcome measurement: at least 6,000

Second-year target/outcome measurement: at least 6,000

Data Source:

Numbers of high-risk youth served in prevention programs are tracked and reported by contracted providers.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of persons trained in MHFA per fiscal year

Baseline Measurement: 6,043
First-year target/outcome measurement: at least 5,500
Second-year target/outcome measurement: at least 5,500

Data Source:

The number trained in MHFA is tracked DBH prevention staff.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 9
Priority Area: School-Based Prevention Education
Priority Type: SAP
Population(s): Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

To delay onset of substance use, reduce use, improve overall school performance, and reduce incidents of violence

Objective:

Continue Missouri's School-based Prevention Intervention and Resource Initiative (SPIRIT) program

Strategies to attain the objective:

- 1) Enhance protective factors and reverse or reduce risk factors for substance use and violence
- 2) Improve academic and social-emotional learning to address risk factors
- 3) Employ interactive techniques that allow for active involvement in learning
- 4) Reinforce prevention skills over time with repeated interventions
- 5) Ensure programming is culturally competent and age appropriate
- 6) Conduct annual fidelity reviews

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number students participating in SPIRIT per fiscal year
Baseline Measurement: 8,031
First-year target/outcome measurement: at least 7,800
Second-year target/outcome measurement: at least 7,800

Data Source:

SPIRIT participation is tracked and reported by the program evaluator MIMH.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Annual report generated
Baseline Measurement: yes
First-year target/outcome measurement: yes

Second-year target/outcome measurement: yes

Data Source:

MIMH generates the annual report which is posted to the DMH public website.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: Prescription Drug Overdose Deaths

Priority Type: SAP

Population(s): PWID

Goal of the priority area:

Reduce overdose deaths

Objective:

- 1) Prevent opioid-related deaths
- 2) Connect individuals experiencing overdose events to SUD treatment

Strategies to attain the objective:

- 1) Increase number of first responders, medical professionals, and other eligible groups trained to carry and administer naloxone;
- 2) Increase public awareness of opioid risks and best practices for assisting during an overdose event

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained to carry and administer naloxone per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 400

Second-year target/outcome measurement: 700

Data Source:

The number of individuals trained and the number of naloxone doses distributed will be tracked by MIMH.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of doses of naloxone distributed per fiscal year

Baseline Measurement: N/A

First-year target/outcome measurement: 4,000

Second-year target/outcome measurement: 6,000

Data Source:

The number of individuals trained and the number of naloxone doses distributed will be tracked by MIMH.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 11

Priority Area: Evidence-based Mental Health Practices

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Continue evidence-based practice to the same standards and fidelity as shown to be effective in research

Objective:

Encourage adoption and provide on-going support to EBP programs

Strategies to attain the objective:

- 1) Continue support for EBP programs.
- 2) Provide on-going monitoring of fidelity in EBP programs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number served in ITCOD per fiscal year

Baseline Measurement: 2,109

First-year target/outcome measurement: at least 1,800

Second-year target/outcome measurement: at least 1,800

Data Source:

Numbers served in ACT and ITCOD are captured in the DMH information system.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number served in ACT per fiscal year

Baseline Measurement: 728

First-year target/outcome measurement: at least 650

Second-year target/outcome measurement: at least 650

Data Source:

Numbers served in ACT and ITCOD are captured in the DMH information system.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 12

Priority Area: Persons who inject drugs intravenously

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Ensure the provision of services to IV drug users in accordance with Substance Abuse Prevention and Treatment Block Grant statutory requirements

Objective:

Provide ongoing support to programs serving IV drug users

Strategies to attain the objective:

- 1) Monitor contractual requirements pertaining to IV drug users
- 2) Continue collecting wait list and capacity management data from contracted providers
- 3) Generate reports for wait list data and interim services billings in support of monitoring efforts
- 4) Increase one-on-one discussions with key provider staff about data reports and target technical assistance as needed

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of IV drug users served in substance use disorder treatment per fiscal year (assuming the same level of funding)

Baseline Measurement: 10348

First-year target/outcome measurement: at least 9,800

Second-year target/outcome measurement: at least 9,800

Data Source:

The number of IV drug users served is captured in the DMH information system. These are individuals for whom a paid claim on a substance use disorder treatment program was submitted to and paid by DMH. Injection drug use is determined from the TEDS data also captured in the DMH information system. The route of substance was IV injection or non-IV injection on the primary, secondary, or tertiary substances.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Percent of SAPT Block Grant funded providers reporting wait list and capacity management data

Baseline Measurement: 100%

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

DBH Research staff monitor wait list and capacity management reporting and follow-up with providers if they do not meet submission deadlines.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority Area: Substance-Abusing Pregnant Women and Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Continue to provide services to pregnant women and women with dependent children

Objective:

Provide ongoing support to providers serving pregnant women and women with dependent children

Strategies to attain the objective:

- 1) Monitor contractual compliance with regard to admission of pregnant women to substance use disorder treatment
- 2) Continue collecting wait list and capacity management data from contracted providers
- 3) Engage TANF referred individuals in substance use disorder treatment at a clinically appropriate level of care

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children served in substance use disorder treatment per fiscal year (assuming the same level of funding)

Baseline Measurement: 6,267

First-year target/outcome measurement: at least 5,900

Second-year target/outcome measurement: at least 5,900

Data Source:

The number of pregnant women and women with dependent children served is captured in the DMH information system. These are individuals for which a paid claim was submitted to and paid by DMH. Pregnancy status and number of dependent children are also captured.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 14

Priority Area: Mental Health Services for Transition-Aged Youth and Young Adults

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Promote collaboration, implementation of effective interventions and supports, and enhanced skills of individuals who work with transition age youth/young adults and their families with behavioral health needs who may also be at risk of First Episode Psychosis.

Objective:

Provide education, training, and technical assistance to providers.

Strategies to attain the objective:

- 1) Develop an inter-departmental "State Team" that focuses on the needs of youth/young adults with behavioral health issues including being at risk of or experiencing First Episode Psychosis.
- 2) Provide education on the importance of advocacy, prevention, and evidence-based treatment.
- 3) Provide training on individualized care planning.
- 4) Expand Integrated Treatment for Co-Occurring Disorders (ITCOD) services to meet the unique needs of the transitional age population.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of education sessions per fiscal year
Baseline Measurement: N/A
First-year target/outcome measurement: 2
Second-year target/outcome measurement: 2

Data Source:

The DBH Children's Team will track education sessions and trainings.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number of provider trainings per fiscal year
Baseline Measurement: N/A
First-year target/outcome measurement: 2
Second-year target/outcome measurement: 2

Data Source:

The DBH Children's Team will track education sessions and trainings.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Number served in ITCOD-TAY program per fiscal year
Baseline Measurement: N/A
First-year target/outcome measurement: 15
Second-year target/outcome measurement: 15

Data Source:

Number served in ITCOD-TAY will be captured in the DMH information system.

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 15
Priority Area: Behavioral Healthcare Services for Children
Priority Type: MHS
Population(s): SED

Goal of the priority area:

To enhance Children's Behavioral Health services by increasing the knowledge of effective services, supports and interventions, enhancing the skills of service providers and expanding services based on the needs of the children, youth and families served.

Objective:

Strengthen behavioral healthcare services for children.

Strategies to attain the objective:

Use the statewide Adolescent CSTAR Committee to advance policy, training, and service delivery for adolescent substance use disorders.
2) Increase dissemination of research, best practices, and success stories.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of meetings of the Adolescent CSTAR Committee per fiscal year
Baseline Measurement: 4
First-year target/outcome measurement: at least 4
Second-year target/outcome measurement: at least 4

Data Source:

The Division of Behavioral Health's Children's Team will track number of trainings and social media posts.

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Number of posts of articles, research, and stories specific to behavioral healthcare for children per fiscal year
Baseline Measurement: N/A
First-year target/outcome measurement: 10
Second-year target/outcome measurement: 10

Data Source:

The Division of Behavioral Health's Children's Team will track number of trainings and social media posts.

Description of Data:

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$19,873,367		\$81,112,395	\$14,976,044	\$75,796,610	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$3,311,005		\$3,834,198	\$0	\$13,720,915	\$0	\$0
b. All Other	\$16,562,362		\$77,278,197	\$14,976,044	\$62,075,695	\$0	\$0
2. Primary Prevention	\$5,299,570		\$0	\$3,907,855	\$2,760,563	\$0	\$0
3. Tuberculosis Services	\$21		\$0	\$0	\$0	\$0	\$0
4. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	\$1,324,893		\$0	\$1,364,865	\$2,280,979	\$0	\$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	\$26,497,851	\$0	\$81,112,395	\$20,248,764	\$80,838,152	\$0	\$0

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planned federal funds include the award for the Opioid STR grant.
Missouri is not an HIV designated state.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			\$0	\$17,086,604	\$466,840,818	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$2,428,645	\$17,889,753	\$0	\$0
7. Ambulatory/Community Non-24 Hour Care		\$5,583,216	\$600,882,361	\$63,944,400	\$144,190,231	\$0	\$0
8. Mental Health Primary*		\$0	\$0	\$730,929	\$600,000	\$0	\$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		\$656,849	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$328,424	\$0	\$861,055	\$1,873,056	\$0	\$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	\$0	\$6,568,489	\$600,882,361	\$85,051,633	\$631,393,858	\$0	\$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	13000	795
Women with Dependent Children	42000	5513
Individuals with a co-occurring M/SUD	158000	17837
Persons who inject drugs	23993	10348
Persons experiencing homelessness	1301	2364

Please provide an explanation for any data cells for which the stats does not have a data source.

Estimates for number in need for 1) pregnant women, 2) women with dependent children, and 3) individuals with a co-occurring M/SUD (any mental illness) are based on estimates from the National Survey on Drug Use and Health (2013-2015). Estimated number in need for persons who inject drugs are based on prevalence estimates from Brady et al. (2008) (<https://www.ncbi.nlm.nih.gov/pubmed/18344002>). Estimated number in need for persons experiencing homelessness (point-in-time) are from the HUD 2016 Continuum of Care Homeless Assistance Programs (https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_MO_2016.pdf). Number in treatment for all cohorts reflect the number served by the Missouri Department of Mental Health in SFY 2016.

Footnotes:

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated in Need	Aggregate Number in Treatment
Pregnant Women	13,000	795
Women with Dependent Children	42,000	5,513
Individuals with a co- occurring M/SUD	158,000	17,837
Persons who inject drugs	23,993	10,348
Persons experiencing homelessness	1,301	2,364

Please provide an explanation for any data cells for which the stats does not have a data source.

Estimates for number in need for 1) pregnant women, 2) women with dependent children, and 3) individuals with a co-occurring M/SUD (any mental illness) are based on estimates from the National Survey on Drug Use and Health (2013-2015). Estimated number in need for persons who inject drugs are based on prevalence estimates from Brady et al. (2008) (<https://www.ncbi.nlm.nih.gov/pubmed/18344002>). Estimated number in need for persons experiencing homelessness (point-in-time) are from the HUD 2016 Continuum of Care Homeless Assistance Programs (https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_MO_2016.pdf). Number in treatment for all cohorts reflect the number served by the Missouri Department of Mental Health in SFY 2016.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FFY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	\$19,873,388
2 . Primary Substance Abuse Prevention	\$5,299,570
3 . Tuberculosis Services	
4 . Early Intervention Services for HIV [*]	
5 . Administration (SSA Level Only)	\$1,324,893
6. Total	\$26,497,851

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Missouri is not an HIV designated state.

Amount of primary prevention funds planned for primary prevention programs (this amount should match the total reported in Table 5a and Table 5b) \$4,127,213.

Amount of primary prevention funds in Table 4, Line 2 that are planned for Prevention-SA resource development (this amount should not include funds reported in Table 5a or Table 5b) \$1,172,357.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	\$383,808
	Selective	\$64,175
	Indicated	
	Unspecified	
	Total	\$447,983
Education	Universal	\$619,871
	Selective	\$1,023,189
	Indicated	
	Unspecified	
	Total	\$1,643,060
Alternatives	Universal	\$8,614
	Selective	\$320,836
	Indicated	
	Unspecified	
	Total	\$329,450
Problem Identification and Referral	Universal	\$30
	Selective	\$31
	Indicated	
	Unspecified	
	Total	\$61

Community-Based Process	Universal	\$1,344,420
	Selective	\$123,283
	Indicated	
	Unspecified	
	Total	\$1,467,703
Environmental	Universal	\$20,044
	Selective	\$4,800
	Indicated	
	Unspecified	
	Total	\$24,844
Section 1926 Tobacco	Universal	\$1,378
	Selective	
	Indicated	
	Unspecified	
	Total	\$1,378
Other	Universal	\$173,333
	Selective	\$39,401
	Indicated	
	Unspecified	
	Total	\$212,734
Total Prevention Expenditures		\$4,127,213
Total SABG Award*		\$26,497,851
Planned Primary Prevention Percentage		15.58 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	\$2,143,258
Universal Indirect	\$408,240
Selective	\$1,575,715
Indicated	
Column Total	\$4,127,213
Total SABG Award*	\$26,497,851
Planned Primary Prevention Percentage	15.58 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input type="checkbox"/>
LGBT	<input type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems				
2. Infrastructure Support				
3. Partnerships, community outreach, and needs assessment		\$19,988	\$2,008,192	
4. Planning Council Activities (MHBG required, SABG optional)				
5. Quality Assurance and Improvement				
6. Research and Evaluation			\$284,022	
7. Training and Education			\$52,500	
8. Total	\$0	\$19,988	\$2,344,714	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³³ Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁹ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴³ SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴⁴ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²⁵ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102?123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52?77

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

- ³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>
- ³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- ³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx
- ³⁶ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
- ³⁷ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>
- ³⁸ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- ³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- ⁴⁰ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. *Health Affairs*. 2014; 33(4): 700-707
- ⁴¹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, *JAMA Psychiatry*. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, *JAMA Psychiatry*. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. *JAMA Psychiatry*. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. *Annals of Emergency Medicine*. 2011; 58(2): 218
- ⁴² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- ⁴³ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- ⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

Health Homes:

The Health Home under the Affordable Care Act is an alternative approach to the delivery of health care services that promises better patient experience and better results than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home but is customized to meet the specific needs of individuals with serious mental illness who often have other co-occurring chronic illnesses. Missouri's initiative enhances the existing psychiatric rehabilitation program by adding nurse care managers and a primary care physician consultant to each community mental health center, and giving the enhanced psychiatric rehabilitation teams access to a wealth of care management reports designed to help them both identify treatment gaps and to assist individuals in developing healthy lifestyles and managing their chronic illnesses. Goals of the CMHC health home initiative are to reduce unnecessary hospitalization and emergency room visits, while improving the health status of the individuals enrolled in the program. Missouri's plan was approved by the Centers for Medicare and Medicaid Services (CMS) in October 2011. Implementation began in January 2012. Under Missouri's plan, 27 Community Mental Health Centers (CMHC) are contracted as Healthcare Home providers. For an individual to be eligible for enrollment in Missouri's Healthcare Home, he/she must meet one of the following three conditions:

- 1) have a serious and persistent mental illness,
- 2) have a mental health condition and a substance use disorder, or
- 3) have a mental health condition or a substance use disorder and one other chronic health condition.

In FY 2014, Missouri began piloting a Children's Health Home program targeting children with co-occurring serious emotional disturbance and obesity.

Disease Management 3700 (DM 3700) & ADA Disease Management (ADA DM):

These programs are the result of collaboration between the Department of Mental Health (DMH) and the state Medicaid agency,

MO HealthNet. DM 3700 started in November 2010 and targets Medicaid-enrolled adults with a serious mental illness and high medical costs who are currently not engaged in treatment at a Community Mental Health Center (CMHC). The ADA DM project started in February 2014 and targets Medicaid-enrolled adults with substance use disorders and high medical costs who are not currently engaged in treatment. DMH funds outreach efforts and the state Medicaid agency funds behavioral health treatment. Healthcare Home providers also participate in the DM 3700 program. Nineteen CSTAR providers (i.e. Missouri's only Medicaid-reimbursable substance use disorder program) participate in the ADA DM project. Each provider added a nurse liaison to assist with care coordination of complex physical health conditions of program participants.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The state supports a service system that provides health home services for individuals with co-occurring mental illness and physical health needs to include use of a primary care physician consultant and nurse care manager who ensure physical health needs are being met for those with mental illness. Health home providers receive a per member per month payment to conduct metabolic screenings, determine needs and coordinate both mental and physical care for individuals served in the health home. The state also supports a service system that provides integrated treatment for those with mental illness and a co-occurring substance use disorder. Those providers implementing the SAMSHA evidenced-based practice have access to additional service codes within the Medicaid rehab option program. Additionally the state conducts fidelity reviews to ensure programs are following the evidenced model. The state's Disease Management programs, DM3700 for individuals with mental illness and ADA DM for individuals with substance use disorder, continue to outreach and engaged Medicaid enrollees with chronic, co-morbid physical health and behavioral health conditions. Many of these individuals are enrolled in Health Home.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ☐ Yes ☒ No

and Medicaid? ☐ Yes ☒ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?
N/A

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ☒ Yes ☐ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education ☒ Yes ☐ No

b) Health risks such as

i) heart disease ☒ Yes ☐ No

ii) hypertension ☒ Yes ☐ No

viii) high cholesterol ☒ Yes ☐ No

ix) diabetes ☒ Yes ☐ No

c) Recovery supports ☒ Yes ☐ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ☐ Yes ☒ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ☐ Yes ☒ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
The Department has recently begun looking into parity for substance use and mental health treatment.

10. Does the state have any activities related to this section that you would like to highlight?

The Department is currently developing a model for integrated treatment by substance use providers that is designed for those with substance use disorders and a co-occurring mental illness to mirror services that are currently being provided by mental health providers.

Please indicate areas of technical assistance needed related to this section

N/A

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)⁴⁸.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁹

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵⁰. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁵¹. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
 - a) Race ☐ Yes ☒ No
 - b) Ethnicity ☐ Yes ☒ No
 - c) Gender ☒ Yes ☐ No
 - d) Sexual orientation ☐ Yes ☒ No
 - e) Gender identity ☐ Yes ☒ No
 - f) Age ☒ Yes ☐ No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ☐ Yes ☒ No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ☒ Yes ☐ No
4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ☐ Yes ☒ No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? ☐ Yes ☒ No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ☐ Yes ☒ No

7. Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health (DBH) convenes a Cultural and Linguistic Competence Work Group comprised of behavioral health service providers across the state. The Work Group concurred with the recommendations of DBH that the Division accept CARF and Joint Commission cultural and linguistic competence accreditation standards as assuring that accredited organizations meet reasonable cultural and linguistic competence national standards. The Work Group also concurred with the recommendation of DBH that it focus on developing recommendations designed to assist and promote the DBH service delivery system as a whole by recommending strategies and resources to DBH, the Coalition, and Coalition members designed to move the system even closer to proficiency. The Work Group is operating within the conceptual framework incorporated in the CLAS standards, and SAMHSA TIP #59. Progress has been made towards identifying a variety of cultural and linguistic competence training resources and opportunities.

Please indicate areas of technical assistance needed related to this section

N/A

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, ($V = Q ? C$)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵⁶ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁵⁸ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁵² United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵³ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵⁴ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ☐ Yes ☐ No
2. Which value based purchasing strategies do you use in your state (check all that apply):
- a) ☒ Leadership support, including investment of human and financial resources.
 - b) ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) ☒ Use of financial and non-financial incentives for providers or consumers.
 - d) ☒ Provider involvement in planning value-based purchasing.
 - e) ☒ Use of accurate and reliable measures of quality in payment arrangements.
 - f) ☒ Quality measures focus on consumer outcomes rather than care processes.
 - g) ☒ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) ☒ The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

In relation to c., e., and f. above, Missouri was chosen as a CCBHC demonstration state with an implementation date of July 1, 2017.

Incentive payments, quality measures and a focus on outcomes are all key components of this project. Missouri specifically chose evidence based and promising practices as requirements for CCBHC inclusion. Those include medication assisted treatment, peer and family supports, and integrated treatment for co-occurring disorders, among others.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode ([RAISE](#)) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ☒ Yes ☐ No
2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ☒ Yes ☐ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The State of Missouri is utilizing the Assertive Community Treatment for Transitional Age Youth (ACT-TAY) model. ACT-TAY is a way of providing many types of services to people with serious mental illness. These teams undergo intensive training utilizing multiple components of the NAVIGATE model. NAVIGATE is a comprehensive program designed to provide early and effective treatment to individuals who have experienced first episode psychosis. Training components of Navigate consist of the following: 1) Individual Resilience Training (IRT)-modular based psychosocial intervention for those recovering from a first episode psychosis. 2) Family Education Training –modular based psychosocial intervention for family members of an individual recovering from a first episode psychosis. 3) Prescriber Training; 4) Supported Employment and Education (SEE). Missouri also provides Transition to Independence (TIP) training as well as Illness, Management, and Recovery (IMR) training to ACT-TAY teams.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
The state of Missouri provides components of NAVIGATE, Transition to Independence (TIP), Illness, Management, and Recovery (IMR), and Motivational Interviewing to all new ACT-TAY teams and refresher courses to existing teams.
4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ☒ Yes ☐ No
5. Does the state collect data specifically related to ESMI? ☒ Yes ☐ No
6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ☒ Yes ☐ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.
- Assertive Community Treatment for Transitional Age Youth (ACT-TAY) is a service delivery model that provides comprehensive, locally-based treatment to people with serious and persistent mental illness, specifically those who have experienced a first episode psychosis.
8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?
- The state of Missouri plans to continue to provide on-going training for the models noted in #2 and to add Motivational Interviewing training.
9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.
- Data collection and reporting are completed quarterly with the following data collected by the provider: Number of days competitively employed; number of times of/for: homelessness, incarcerated, hospitalized for psychiatric and medical reasons, number of times for in-patient/residential substance use treatment; number of emergency room visits for physical/psychiatric reasons; use of primary care physician; current living arrangement; stage of substance use treatment; education; tobacco use; and legal status.
10. Please list the diagnostic categories identified for your state's ESMI programs.
- 1) Schizophrenia
 - 2) Schizo-affective Disorder
 - 3) Bipolar Disorder
 - 4) Major Depressive Disorder
 - 5) Psychotic Disorder
- Does the state have any activities related to this section that you would like to highlight?
- The state of Missouri currently operates 8 ACT-TAY teams currently with plans to add a 9th team in September of 2017.
- Please indicate areas of technical assistance needed related to this section.
- N/A

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? ☒ Yes ☐ No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
Consumers and their caregivers are engaged through an individualized assessment and treatment planning process that focuses on recovery needs and preferences of the individual in all areas of life. The provider conducts the face-to-face dialog with the individual in order to know what the individual's needs and desires are in life in order to provide the array of services that would best help them reach their goals.
4. Describe the person-centered planning process in your state.
The expectation is that providers meet face-to-face with the individual and their family/natural supports to assess their treatment needs and develop recovery goals that the person wants while offering service interventions that can help the person achieve their recovery goals. The treatment team provides input and develops a written treatment plan that is reviewed and signed by the individual and the individual receives a copy. The expectation is that the treatment plan is revised and updated in an on-going manner to reflect achievement of goals/objectives and the addition of any new goals and objectives throughout the year.
Does the state have any activities related to this section that you would like to highlight?
The Department updated the assessment and treatment planning process to streamline the assessment in order to improve access to care. More time is allowed for development of the person-centered plan so that providers may better know and understand the needs of the individual. Additionally, requirements for an annual assessment were reduced to lessen the burden for individuals and providers and allow for more of a focus on treatment needs rather than documentation.
Please indicate areas of technical assistance needed related to this section.
N/A

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? ☐ Yes ☒ No
2. Are there any concretely planned initiatives in our state specific to self-direction? ☐ Yes ☒ No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed:
- b) What are the eligibility criteria?
- c) How are budgets set, and what is the scope of the budget?
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
- e) What, if any, research and evaluation activities are connected to the initiative?
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☒ Yes ☐ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? ☒ Yes ☐ No

Does the state have any activities related to this section that you would like to highlight?

The Division of Behavioral Health implemented an annual SABG monitoring of DBH contracted providers. The Division has checks and balances to ensure block grant funds are spent appropriately, for example making available a menu of services that may be provided, setting up controls within our billing portal to ensure accurate billing and a comprehensive system is in place between clinical, fiscal and monitoring entities within the Division to ensure contract compliance. The billing system allows us to run utilization reports that are used to identify and correct any areas of concern.

Please indicate areas of technical assistance needed to this section

N/A

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
Missouri does not have any federally recognized tribes.
2. What specific concerns were raised during the consultation session(s) noted above?

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ☒ Yes ☐ No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ☒ Yes ☐ No
 - ☒ Data on consequences of substance using behaviors
 - ☒ Substance-using behaviors
 - ☒ Intervening variables (including risk and protective factors)
 - ☐ Others (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - ☒ Children (under age 12)
 - ☒ Youth (ages 12-17)
 - ☒ Young adults/college age (ages 18-26)
 - ☒ Adults (ages 27-54)
 - ☒ Older adults (age 55 and above)
 - ☒ Cultural/ethnic minorities
 - ☐ Sexual/gender minorities
 - ☒ Rural communities
 - ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- ☐ Archival indicators (Please list)
- ☒ National survey on Drug Use and Health (NSDUH)
- ☒ Behavioral Risk Factor Surveillance System (BRFSS)
- ☒ Youth Risk Behavioral Surveillance System (YRBS)
- ☐ Monitoring the Future
- ☐ Communities that Care
- ☒ State - developed survey instrument
- ☐ Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ☒ Yes ☐ No

If yes, (please explain)

The Division supports various targeted initiatives in the state based on need.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

Prevention providers must submit an annual Strategic Work Plan and Needs Assessment, using the Strategic Prevention Framework.

Please indicate areas of technical assistance needed related to this section

N/A

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? ☒ Yes ☐ No
 If yes, please describe
 The Division of Behavioral Health (DBH) and the Missouri Credentialing Board worked together to establish a three-tiered credentialing process to reach the entire spectrum of prevention professionals. All three levels of credentialing are marked by training, experience and education. DBH requires that all funded prevention programs obtain at least the first credential level.
2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? ☒ Yes ☐ No
 If yes, please describe mechanism used
 DBH and the Statewide Training and Resource Center (STRC) provide technical assistance and training to contracted prevention providers. The STRC assesses the training needs across the state and provide the necessary assistance to help prevention staff and programs be successful.
3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ☒ Yes ☐ No
 If yes, please describe mechanism used
 Primary Prevention providers are required to assess community readiness as a part of their annual Strategic Work Plan. The providers use the Tri-Ethnic Center Community Readiness Survey.
 Does the state have any activities related to this section that you would like to highlight?
 Please indicate areas of technical assistance needed related to this section

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ☒ Yes ☐ No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ☒ Yes ☐ No ☐ N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) ☒ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) ☒ Timelines
 - c) ☒ Roles and responsibilities
 - d) ☒ Process indicators
 - e) ☒ Outcome indicators
 - f) ☒ Cultural competence component
 - g) ☒ Sustainability component
 - h) ☐ Other (please list):
 - i) ☐ Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ☒ Yes ☐ No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ☐ Yes ☐ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

5. Yes, the Division requires providers to use evidence-based programs and environmental strategies. SAMHSA's publication, identifying and Selecting Evidence-Based Interventions for Substance Abuse Prevention, serves as a guide, which provides the following definition for evidence-based programs:

- ? Inclusion in a federal list or registry of evidence-based interventions
- ? Being reported (with positive effects) in a peer-reviewed journal

? Documentation of effectiveness based on the following guidelines:

1. The intervention is based on a theory of change that is documented in a clear logic or conceptual.
2. The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature.
3. The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects.
4. The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review, local prevention practitioners, and key community leaders as appropriate (e.g., officials from law enforcement and education sectors or elders within indigenous cultures).

? Missouri uses the Strategic Prevention Framework model to implement the four guidelines. The process includes:

- o Assessment of the community's needs and readiness
- o Capacity building to mobilize and address the needs of the community
- o Development of a prevention plan to identify the activities, programs, and strategies necessary to address the needs.
- o Implementation of the prevention plan.
- o Evaluation of the results to achieve sustainability and cultural competence.

? Missouri identifies appropriate strategies based on validated research, empirical evidence of effectiveness, and the use of local, state, and federal key community prevention leaders such as National Prevention Network, Southwest Regional Expert Team, and SAMHSA's Center for Substance Abuse Prevention.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

N/A

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) ☐ SSA staff directly implements primary prevention programs and strategies.
 - b) ☒ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) ☒ The SSA funds regional entities that provide training and technical assistance.
 - e) ☒ The SSA funds regional entities to provide prevention services.
 - f) ☐ The SSA funds county, city, or tribal governments to provide prevention services.
 - g) ☐ The SSA funds community coalitions to provide prevention services.
 - h) ☐ The SSA funds individual programs that are not part of a larger community effort.
 - i) ☐ The SSA directly funds other state agency prevention programs.
 - j) ☐ Other (please describe)
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
Prevention providers disseminate ATOD information within their communities. The Statewide Training and Resource Center disseminates ATOD information statewide. Partners in Prevention disseminates ATOD information to the 21 College campuses statewide that they work with. Examples include fact sheets on prescription drug misuse, information on drug trends, media campaigns, and county level data fact sheets.
 - b) Education:
Prevention providers work with school districts in their area to provide evidence based programming that is specific to their needs such as the Too Good for Drugs, PeaceBuilders, and Second Step curriculum. After school programming for high risk youth, mentoring programs, and heroin specific education is offered.
 - c) Alternatives:
Prevention providers work with their local communities and coalitions to provide alternative drug free activities such as after-proms, Lock-Ins, and Safe and Drug Free Halloween events and New year's Eve Celebrations.
 - d) Problem Identification and Referral:

The school based providers provide referral and assessment services as needed. The statewide prevention provider that works specifically with the deaf and hard of hearing population makes referrals to treatment centers as needed.

e) Community-Based Processes:

All prevention providers collaborate with other agencies and coalitions in their local communities to provide effective programming that meets their needs. Prevention providers and local coalitions collaborate to conduct Town Hall meetings on topics such as underage drinking and Heroin. Prevention providers assist coalitions with developing and distributing their information in ways of direct mailings, brochures, info packets, websites, coalition advertising and marketing.

f) Environmental:

Prevention providers work with their local communities, coalitions, and elected officials to work on city/county ordinances, school district policies and state policies. Efforts have included local prescription drug monitoring programs and creating city ordinances that increased the age to purchase tobacco products to 21.

- 3.** Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ☒ Yes ☐ No

If yes, please describe

All prevention providers submit an annual Strategic Work plan , year end report, and a budget at the beginning and end of the fiscal year. They also submit a monthly report to DBH detailing the services provided that month. Annual reviews are conducted on all prevention providers to make sure they are in compliance with contract requirements.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

N/A

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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- **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ☒ Yes ☐ No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) ☒ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) ☒ Includes evaluation information from sub-recipients
- c) ☒ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) ☒ Establishes a process for providing timely evaluation information to stakeholders
- e) ☒ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) ☐ Other (please list:)
- g) ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) ☒ Numbers served
- b) ☒ Implementation fidelity
- c) ☒ Participant satisfaction
- d) ☒ Number of evidence based programs/practices/policies implemented
- e) ☒ Attendance
- f) ☒ Demographic information
- g) ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) ☒ 30-day use of alcohol, tobacco, prescription drugs, etc
- b) ☐ Heavy use
- ☒ Binge use

- ☒ Perception of harm
- c)** ☒ Disapproval of use
- d)** ☒ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)** ☐ Other (please describe):

Footnotes:



DEPARTMENT OF MENTAL HEALTH * DIVISION OF BEHAVIORAL HEALTH

The Missouri Division of Behavioral Health manages programs and services for people who need help for a mental illness or alcohol or drug problem. Services available are prevention, education, evaluation, intervention, treatment, and rehabilitation.

The Division of Alcohol and Drug Abuse (ADA) was created in 1975 and established in statute in 1980 (RSMo 631.010) as part of the Department of Mental Health. In spring 2013, the Divisions of Comprehensive Psychiatric Services and Alcohol and Drug Abuse merged into one division, the Division of Behavioral Health (DBH).

DBH Prevention Priorities

The Division's prevention program covers all segments of the population at potential risk for drug and alcohol use. However, the primary focus is on children who have not yet begun use. Research finds that brain changes caused by drinking before age 15 could predispose adolescents to a lifetime of alcohol dependency. Children are drinking earlier and at more dangerous levels than they did many years ago.

Prevention Goals

Create positive community norms, policy change, reduced alcohol, tobacco and other drug availability, and increased enforcement at the state and community level through the implementation of effective, evidence-based prevention programs and environmental strategies to prevent and reduce substance use and its consequences for youth, adults and families in Missouri.

Prevention Objectives

- By FY 2020, consequences of substance use in Missouri will be reduced as a result of prevention programs implementing effective and evidenced-based programs and strategies and the Strategic Prevention Framework.
 - Reduce alcohol, tobacco and drug use among youth.
 - Reduce alcohol and drug use among pregnant women.
 - Reduce alcohol and drug use among general population.
 - Reduce unnecessary accidents and emergency room visits.

Prevention Outcomes

- Reduced accidents and emergency room visits and hospitalization as a result of alcohol consumption by youth and adults.
- Reduced accidents and emergency room visits and hospitalization related to marijuana and other drugs by Missouri's youth and adults.
- Increased drug free births

Programs and Numbers Served

Contracted Prevention Providers	Number of Programs	Numbers Served
Prevention Resource Centers	11	161,591
Direct Programs/Services	7	6,399
School-Based Programs	6	8,175
College-Based Program/Services	1	160,400
Deaf & Hearing Impaired Services	1	4,021
Partnerships for Success	6	225,680



DBH Prevention Targets

Binge Drinking: By FY 2020, reduce binge drinking among Missouri's youth and young adults from FY 2016 baselines.

- The percentage of Missourians age 12 to 20 who engaged in binge alcohol use in the past month was higher than that for the United States (14.6 percent vs. 14 percent) (NSDUH, 2013-2014).
- Students who binge drink are at increased risk of being assaulted (including sexually) or injured, or experiencing academic and legal problems (U.S. Department of Health and Human Services, 2007).

Substance Use Onset: By FY 2020, delay onset of first use of alcohol and marijuana among youth from FY 2016 baselines.

- Among Missouri students who have ever used alcohol, the average age of first use is 13.43. The average age of first use of marijuana is 14.11 (Missouri Student Survey 2016).

Current Use of Alcohol and Marijuana: By FY 2020, reduce use of alcohol and marijuana among youth in past 30 days from FY 2016 baselines.

- Research indicates that individuals who start drinking early in life are at increased risk to develop alcohol addiction and to incur alcohol-related injuries later in life (Hingson et al, 2000; Hingson et al, 2006).
- Marijuana smoke contains more carcinogens than tobacco smoke (NIDA, 2009).
- Missouri's youth ages 12 to 17 are drinking and using marijuana at rates similar to that of the nation as a whole (NSDUH, 2014-2015).
- In a given year, about 12,000 Missourians receive treatment for alcohol use disorders through the Missouri Division of Behavioral Health. Another 7,600 receive treatment for marijuana (Smith et al, 2016).
- In 2014, approximately 57,000 hospital and emergency room admissions across the state were alcohol-related (Smith et al, 2016).

Risk Awareness: By FY 2020, increase the number of youth who perceive risk/harm of alcohol, cigarettes, marijuana and other drug use from FY 2016 baselines.

- Majority of Missouri youth believe they risk harm if they engage in binge drinking (78.5 percent), smoking a pack of cigarettes per day (85.1 percent), or smoking marijuana (63.5 percent) (Missouri Student Survey, 2016).
- [National data to be requested from SAMHSA Office of Applied Studies.]

Prescription Misuse: By FY 2020, reduce prescription drug misuse among young and older adults from FY 2016 baselines.

- About 4 percent of Missouri's youth and 9 percent of its young adults have misused prescription drugs in the past year (NSDUH, 2013-2014).
- National data suggests that roughly 3 percent of older adults are unintentionally misusing prescription drugs (SAMHSA, 2007; NIDA, 2001). [Missouri data to be requested from the SAMHSA Office of Applied Studies.]
- In a given year, nearly 1,200 Missourians are admitted to substance use disorder treatment for a prescription drug problem (Smith et al, 2016).

Youth Use of Tobacco: By FY 2020, reduce smoking and other tobacco use among Missouri's youth from FY 2016 baselines.

- Missouri's youth ages 12 to 17 are smoking at a higher rate than compared to that of the nation (6.95 percent in the past month vs. 4.53 percent) (NSDUH, 2014-2015).
- An estimated 10,121 Missourians die each year from smoking (Smith et al, 2016).
- Smoking has been implicated in a number of diseases including various cancers, respiratory diseases, fertility and pregnancy complications, cataracts, hip fractures, low bone density, and peptic ulcer disease (U.S. Department of Health and Human Services, 2004).

Substance Use among Pregnant Women: By FY 2020, reduce substance use among pregnant women.

- National data suggests that about 5 percent of pregnant women use illicit drugs, about 10 percent use alcohol, and 16 percent use tobacco (SAMHSA, 2008).
- [Missouri data to be requested from the SAMHSA Office of Applied Studies.]

Youth Access to Tobacco: Continue to meet the requirements of the Synar Amendment for reducing the sale and distribution of tobacco products to individuals under the age of 18.

- The federal Synar regulation requires all states to reduce the number of successful illegal purchases by minors to no more than 20 percent of attempts in each state per year.
- Missouri has reduced the percentage of its retailers failing tobacco checks from 40 percent in 1996 to 7.7 percent in 2016 – as measured by the state’s annual Synar survey.

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- Hingson, R.W., Heeren, T., Jamanka, A., and Howland, J. (2000). "Age of Drinking Onset and Unintentional Injury Involvement After Drinking." *JAMA* 2000 Sep 27;284(12):1527-33.
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- U.S. Department of Health and Human Services (2007). The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking. (<http://www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf>)

Missouri Prevention NOMs

Prevention NOMs	Ages 12-17			Ages 18+		
	2013	2014	2013-14 Variance	2013	2014	2013-14 Variance
30-day Use						
Alcohol	12.8%	11%	1.8%	56.4%	55.6%	0.80%
Cigarettes	8.9%	8.1%	0.80%	30.8%	30.9%	-0.10%
Other Tobacco Products	6.5%	5.5%	1.00%	10.1%	10.1%	0.00%
Marijuana	7.5%	5.1%	2.40%	6.8%	8.1%	-1.30%
Illegal Drugs Other than Marijuana	4.1%	2.4%	1.70%	2.4%	2.6%	-0.20%
Perception of Risk						
Alcohol	74.7%	75.3%	-0.60%	72.8%	71.5%	1.30%
Cigarettes	90.4%	91.2%	-0.80%	91.6%	91.2%	0.40%
Marijuana	72.4%	70.9%	1.50%	62.7%	55.6%	7.10%
Age of First Use						
Alcohol	13.6	14.1	-0.5	17.0	17.0	0
Cigarettes	13.2	13.4	-0.2	15.9	15.8	0.1
Other Tobacco Products	14.1	14.0	0.1	19.3	19.2	0.1
Marijuana	14.1	14.1	0	18.0	18.0	0
Illegal Drugs Other than Marijuana	12.9	12.8	0.1	20.0	20.4	-0.4
Disapproval of Youth Use						
Cigarettes	89.8%	91.0%	-1.20%			
Experimental Use of Marijuana	79.5%	79.2%	0.30%			
Regular Use of Marijuana	79.5%	80.2%	-0.70%			
Alcohol	87.5%	87.7%	-0.20%			
Perception of Workplace Policy						
Random Alcohol/Drug Test in the Workplace				39.6%	34.5%	5.10%
Past Year Family Communications Around Drug and Alcohol Use						
Parent-child discussion about dangers of substance use	55.8%	57.6%	-1.80%	n/a	n/a	n/a
Exposure to Prevention Message						
Exposure to Prevention Message	88.1%	85.6%	-2.5%			

Data pre-populated in FFY 2016 - 2017 SAPT BG.

Prevention Strategies and Activities

The Division of Behavioral Health contracts with various prevention agencies across the state to plan and implement prevention strategies and programs. The state's investment in the infrastructure of the Statewide Training and Resource Center and Prevention Resource Center (PRC) network, and Partners in Prevention program on state college campuses, positions Missouri to achieve population-level changes in substance use patterns locally and across the state. The Prevention Resource Centers' scope of work incorporates the Strategic Prevention Framework as well as many other specific elements to promote positive prevention outcomes.

These funded programs are required to:

- Develop, implement and evaluate a comprehensive strategic plan with identified target outcomes based on community needs.
- Utilize data to identify prevention needs, gaps, and resources.
- Implement evidence-based programs and strategies that address identified gaps and needs. Implement strategies with fidelity.
- Implement the Strategic Prevention Framework.
- Evaluate services and progress toward outcomes.
- Have formal agreements with multiple community-level partners to collaborate in community planning and implementation.
- Select and implement prevention practices that are culturally appropriate.
- Select a comprehensive package of evidence-based strategies that are likely to have a positive impact on the community. The selected strategies should address one or more of the Center for Substance Abuse Prevention's six core strategies.
- Address sustainability.
- Report NOMs data and other information to DBH in a timely manner.
- Participate in public policy and advocacy support and training.
- Promote a unified prevention message across the state and collaborate on media campaigns.
- Implement tobacco merchant education to retailers (PRCs).
- Be a DBH certified program, which means each funded program must be in compliance with the Core Rules for Psychiatric and Substance Abuse Programs, General Program Procedures, and the Certification Standards for Alcohol and Drug Abuse programs.

Funded program staff are required to:

- Meet DBH Certification Standards for Personnel.
- Acquire and maintain the Missouri Prevention Specialist (MPS) credential.
- Participate in Substance Abuse Prevention Specialist Training (SAPST).

- Use data to identify local needs and develop strategic plans.
- Assess effectiveness of prevention strategies.
- Conduct evaluation and monitor progress toward goals.
- Plan for workforce development.

Other Strategies and Activities

➤ **Show Me Zero Suicide Initiative Grant**

Aims to reduce youth suicide through an integrated systems-level approach, which includes establishing a continuity of care model for youth at risk of suicide and promoting the adoption of suicide prevention as a core priority of youth-serving institutions, such as hospitals and schools. Through collaboration with these organizations, this initiative is effectively identifying youth ages 10-24 who are at risk for suicide and providing them immediate linkage to intensive services and follow-up care.

Services are being focused on a five-county region in western Missouri, centered on Jackson County, which includes Kansas City, as well as surrounding counties with more rural areas.

The overall aim of the *Show Me Zero Youth Suicide Initiative* is to reduce suicides and suicide attempts by accomplishing three major goals:

- 1) Improve the system of care of suicidal youth who use hospital emergency departments, in-patient psychiatric facilities, and/or crisis hotlines.
- 2) Improve the capacity of school systems to identify, respond, and refer youth at risk of suicide.
- 3) Strengthen overall prevention efforts for at-risk youth populations in other settings.

➤ **Signs of Suicide (SOS) Training**

DMH contracted Prevention Resource Center (PRC) staff have been trained as SOS Trainers. The PRC's provide this training to school staff across the state.

➤ **Zero Suicide Initiative**

The Coalition for Community Behavioral Healthcare, in collaboration with DMH and the national Suicide Prevention Resource Center, has hosted a Show Me Zero Suicide Learning Collaborative for Community Mental Health Centers the last two years with another one planned next year. DMH facilities are also being educated on the Zero Suicide framework.

➤ **Partnerships for Success Grant**

In 2015, DMH was awarded a five-year Partnerships for Success grant to target substance use among youth ages 12 to 18 in southeast Missouri. A resiliency approach is being used to reduce risk factors and promote protective factors common to alcohol, tobacco, and other drug use, including prescription drug misuse. Missouri's program is designed to 1) enhance protective factors and reverse or reduce risk factors, 2) address all forms of substance use, 3) increase academic and social competence, and 4) present consistent, community-wide messaging. Interventions target the individual, family, and community ecological levels to support positive youth development and are based upon the Strategic Prevention Framework.

➤ **Missouri Heroin Overdose Prevention and Education (MO HOPE) Project**

In 2016, DMH was awarded a 5-year federal grant to directly address the opioid crisis through overdose education and naloxone distribution. Priority area is the Eastern Region.

➤ **Opioid State Targeted Response to the Opioid Crisis (STR) Grant**

In May 2017, DMH was awarded a 2-year federal grant to improve access to evidence-based practices in prevention, treatment and recovery specific to opioid misuse. The amount of award is \$10 million for each year.

Prevention initiatives include:

- Overdose education and naloxone will be provided to pharmacies, jails and recovery settings.
- Clinical trainings will be provided to pharmacies to increase naloxone access for individuals without an outside prescription.
- ECHO expert panelists will educate providers about the treatment of chronic pain.
- Generation Rx program will be implemented in schools in St. Louis and Springfield to educate on medication safety, etc.

➤ **Mental Health First Aid (MHFA)**

DMH contracted Prevention Resource Center (PRC) staff have been trained as Adult and Youth MHFA Trainers. The PRC's provide this training across the state.

Implementation Plan

All DBH contracts for prevention services are in place for one year, from July 1st until June 30th the following year. Contracts are monitored on a monthly basis by state-level prevention staff. Contracts are renewed annually based on availability of funding, fulfillment of contract terms, and effectiveness of services. Contracts are re-bid as necessary.

Prevention Resource Centers are required to submit a Strategic Work Plan to DBH annually for approval. Once approved, these plans are monitored by DBH staff to ensure progress toward identified goals.

The Statewide Training and Resource Center provides training and technical assistance to contracted prevention providers. They assess the training needs across the state and provide the necessary assistance to help prevention programs be successful.

The Statewide Epidemiology Workgroup will assist the state in making the link between the data they generate and the prevention objectives outlined, as well as providing local programs with data that drives the selection of their program strategies that will also address the statewide targets.

Prevention Infrastructure Goals

- DBH will ensure that prevention services are part of a recovery-oriented system of care.
- DBH will ensure that treatment and prevention services are linked with broader healthcare and social service systems.
- DBH will continue working with the prevention network and coalitions to broaden their scope of work to include preventing mental, emotional, and behavioral disorders, as many of the risk and protective factors overlap, and continue linking them with potential opportunities.

DBH will continue to require contracted prevention providers to submit demographic data to DBH monthly. The data collected is used to complete the Prevention sections of the Substance Abuse and Mental Health Services Administration Substance Abuse Prevention and Treatment Block Grant application, special requests from National Association of State Alcohol and Drug Abuse Directors, Data Consolidated Coordinating Center, and Center for Substance Abuse Prevention, and for state-level reporting.

Workforce Development

- Continue to develop Missouri's prevention workforce.
- Make available prevention workforce opportunities and a training system within the Missouri Statewide Training and Resource Center.

Missouri has made significant steps in preparing the substance use prevention workforce by establishing a credentialing process. The Division of Behavioral Health and the Missouri Credentialing Board (MCB) worked together to establish a three-tiered credentialing process to reach the entire spectrum of prevention professionals. All three levels of credentialing are marked by training, experience and education. Missouri has over 150 prevention professionals with a credential. The Division of Behavioral Health requires that all funded prevention programs obtain at least the first credential level. ACT Missouri and the MCB coordinate trainings across the state to assist individuals in acquiring the skills and experience needed to move across credentialing levels. More information about the three credential levels can be found at www.missouricb.com.

Prevention workforce characteristics have significant implications for prevention programming. The strategic prevention framework is a rigorous model that requires an understanding of prevention science and the ability to perform numerous capacity building, program management, and evaluation activities. In looking toward the future, DBH realizes it is important to cultivate and support a workforce that can meet the demands of changing prevention system environments.

Evaluation Plan

The move to science-based prevention called for sound approaches to needs assessment, resource allocation, program monitoring and improvement, and documentation of prevention outcomes. Evaluation activities are integral to program management and to the Strategic Prevention Framework. Evaluation efforts should provide support for the planning, implementation and improvement of prevention efforts in Missouri. At the beginning of the programming process, needs must be assessed and programs and strategies must be identified to address needs. Once programs have been implemented, evaluation efforts can serve to assess the degree to which prevention efforts have been successfully implemented.

State Level:

- Assure Data is available to communities by monitoring state and local drug trends:
 - Missouri Student Survey and Report
 - ADA Status Report

- Missouri Data Querying Site
- DBH contracted prevention providers will submit demographic data to DBH.
- DBH monitors local prevention providers for quality of service delivery and fidelity.
- DBH and ACT Missouri train providers on evaluation skills and techniques.
- ACT Missouri will continue to produce a year end coalition and Prevention Resource Center outcome/success report.

Local Level:

- Prevention Resource Centers (PRCs) annually conduct community needs assessment to assist in developing their strategic work plans. PRCs evaluate their programs for effectiveness. (*See PRC contract.*)

The Division of Behavioral Health will provide data analysis in support of a Prevention Needs Assessment. DBH will continue to annually publish the *Status Report on Missouri's Alcohol and Drug Misuse Problems*. This report is updated annually and issued online by DMH. The purpose of this document is to support research, education, policy-making, planning, and evaluation activities. As a reference tool, the report provides consistent sets of year-to-year data on alcohol and drug usage rates and reported events that result from substance abuse. In addition, DBH has developed an online reporting website for the Missouri Student Survey, a biannual consumption and risk and protective factor survey of students ages 12-17. This will allow all communities in Missouri to locate and run basic analyses on the data, drilling down to the local level.

The State Epidemiology Workgroup (SEW) will assess data trends and geographical variations to develop an assessment of prevention need in the state and prepare an annual summary report prioritizing areas of need. The work by the SEW will help coalitions conduct needs assessments, planning, and subsequent evaluations. The SEW will continue to monitor drug trends across the state. The SEW will assist the state in making the link between the data that they generate and the prevention objectives outlined, as well as providing local programs data that drive selection of local program strategies that will also address the statewide targets.

The Division of Behavioral Health has a longstanding partnership with the Missouri Institute of Mental Health who is dedicated to providing research, evaluation, policy and training expertise to the Department and other organizations.

Synar

DBH will continue to ensure that Missouri stays in compliance with the Synar Amendment and will maintain a retailer violation rate lower than 20%. Contracted PRCs will continue to provide merchant education to tobacco retailers across the state. DBH will continue to collaborate with the Division of Alcohol and Tobacco Control (ATC) on enforcement and training efforts.

% of MO Retailers Failing Tobacco Checks		Meet Synar?
2016	7.7%	yes
2015	11.3%	yes
2014	7.2%	yes
2013	7.4%	yes
2012	10.4%	yes
2011	10.2%	yes
2010	10.6%	yes
Baseline 1996	40.30%	N/A

Calendar year is provided.

Sustainability

DBH ensures that activities are sustainable by training funded programs and coalitions in approaches that promote sustainability at every step of the Strategic Prevention Framework. Funded programs will be expected to build sustainability into their data collection process, plan and approach by building community readiness; seeking buy-in from community leaders; using evidence-based approaches that are monitored and evaluated; leveraging funds whenever possible; and collaborating with local prevention partners. Centralizing prevention data is also an essential component of sustainment. A good beginning was made with the SEW and the Strategic Prevention Framework State Incentive Grant. The DBH Status Report, DHSS's MICA system and the Missouri Student Survey are ongoing data resources for agencies and communities. Also, DBH has developed a data querying site that is available to the public.

DBH will continue to develop Missouri's prevention workforce. DBH, through a contract with the Statewide Training and Resource Center (STRC), will continue to offer workforce development opportunities. The STRC will also collaborate with our Missouri Credentialing Board.

DBH will continue to partner with other state agencies/groups providing prevention services across the state to leverage funds and opportunities whenever possible. These agencies include but are not limited to: the Department of Health and Senior Services, Department of Elementary and Secondary Education, Division of Highway Safety, and Department of Public Safety.

DBH will continue working with the prevention network and coalitions to broaden their scope of work to include preventing mental, emotional, and behavioral disorders, as many of the risk and protective factors overlap, and continue linking them with potential opportunities.

Cultural Competence

Through current projects DBH continues to develop the understanding needed to guide the identification and implementation of culturally, competent, evidence-based programs and strategies following the assessment of risk and protective factors, readiness, assets and resources, and priorities. Staff and funded program staff should be familiar with local communities' cultures and languages, and also have additional cultural skills and knowledge that lend them to working with any new emerging cultural situations which may present them. Training is provided to staff and funded program staff as needed.

The State Advisory Councils for the Division of Behavioral Health will continue to contribute to the process of identifying culturally responsive, evidence-based programs and strategies. Also, DBH and MIMH has extensive experience implementing and evaluating culturally appropriate/competent prevention interventions. DBH will conduct annual assessments of the prevention system to ensure that programs, policies, and services are offered in ways that are meaningful to recipients consistent with their cultural world views. DBH will continue to devise strategies that enhance and guarantee cultural competence throughout the system.

Enclosures

Prevention Budget

PRC Contract

ACT MO Contract

Prevention Budget

FY 2017 Prevention Costs (Approp) Updated						
Description	Fund	FTE	Personal Services Budget	Expense & Equipment/PSD Budget	Total Cost	% of Total Prev Cost
Direct Staff Prevention	GR	0.06	\$ 26,788	\$ -	\$ 26,788	
Direct Staff Prevention	FED	9.03	\$ 482,256	\$ 428,170	\$ 910,426	
Total Direct Prevention Staff		9.09	\$ 509,044	\$ 428,170	\$ 937,214	
Administration *	GR	1.06	\$ 61,613	\$ 1,480	\$ 63,093	
Administration *	FED	1.47	\$ 63,404	\$ 12,511	\$ 75,914	
Administration *	HIF	0.07	\$ 3,418	\$ -	\$ 3,418	
Total Direct and Administrative Prevention Costs		11.68	\$ 637,479	\$ 442,161	\$ 1,079,640	10.3%
Prevention Services					\$ 9,370,128	89.7%
Total Prevention Cost					\$ 10,449,768	

*These figures are prorated based on total direct dollars and services for prevention.

FY 2018 Prevention Costs Requested						
Description	Fund	FTE	Personal Services Budget	Expense & Equipment/PSD Budget	Total Cost	% of Total Prev Cost
Direct Staff Prevention	GR	0.06	\$ 26,788	\$ -	\$ 26,788	
Direct Staff Prevention	FED	9.03	\$ 502,491	\$ 407,935	\$ 910,426	
Total Direct Prevention Staff		9.09	\$ 529,279	\$ 407,935	\$ 937,214	
Administration *	GR	1.14	\$ 66,532	\$ 1,598	\$ 68,130	
Administration *	FED	1.58	\$ 68,465	\$ 13,509	\$ 81,974	
Administration *	HIF	0.08	\$ 3,691	\$ -	\$ 3,691	
Total Direct and Administrative Prevention Costs		11.89	\$ 667,967	\$ 423,042	\$ 1,091,009	9.5%
Prevention Services					\$ 10,370,128	90.5%
Total Prevention Cost					\$ 11,461,137	

*These figures are prorated based on total direct dollars and services for prevention.

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Division of Behavioral Health supports and expects a variety of basic and evidence based services within the mental health service system including community support services, peer and family support services, medication services, school based services, disease management and health homes in order assist individuals in managing their mental and physical health conditions while being supported to live in the community. Evidence based practices are supported and encouraged, such as assertive community treatment, integrated treatment for co-occurring disorders, and supported employment, which are shown to increase outcomes for individuals receiving evidence based services. The Division of Behavioral Health expect providers to provide an array of housing options and intensive services in order to keep individuals in the housing of their choice.

Treatment Family Home - "home-like" setting in which intensive therapeutic mental health interventions are provided.

Professional Parent Home - "home-like" setting that provides intensive therapeutic mental health interventions for a child. Only one child is placed in a Professional Parent Home.

Intensive Evidence Based Practice – This service includes implementation of supports for treatments that have been proven demonstrably effective for children.

Psychosocial Rehabilitation - A combination of goal-oriented and rehabilitative services provided in a group setting to improve or maintain the child's ability to function as independently as possible with their family or community.

Day Treatment - This service offers an alternative form of care to children who have serious emotional disturbance and who require a level of care greater than can be provided by the school or family, but not as intensive as inpatient service.

Family Assistance – These services are provided for the child and/or family. Activities provided in the delivery of services may include home living and community skills, communication and socialization, leisure activities for the child, arranging for appropriate services and resources available in the community.

Family Support - Services are provided for a family member of a child who had or currently has a behavioral or emotional disturbance disorder and may involve a variety of related activities to the development or enhancement of the service delivery system.

Community Support – Services are designed to coordinate and provide services and resources to children and their families as necessary to promote resilience.

Targeted Case Management - This service includes arrangement, coordination and participation in the assessment to ensure that all areas of the child and family's life are assessed to determine unique strengths and needs.

Respite – Temporary care provided by trained, qualified personnel, on a time-limited basis, for the purpose of meeting family needs and providing mental health stabilization.

Wraparound - providing direct and indirect service to assist in maintaining the child in regular home, school and/or community placement to ensure the functional success of the child in the community. Types of services may include basic needs supports, transportation supports, social-recreational supports, clinical/medical supports and other supports.

Assertive Community Treatment (ACT) – provision of multiple types of services to transitional age youth (TAY) with serious emotional disturbance which are received within their own home 24 hours per day, 7 days a week. Services provided to TAY are round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community.

Integrated Treatment for Co-occurring Disorders (ITCD) – Evidence-based model of treatment for people with serious mental illnesses and co-occurring substance use disorders where combined treatment is received for mental illness and substance use disorders.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

- | | | |
|-----------|--|---|
| a) | Physical Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) | Mental Health | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) | Rehabilitation services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) | Employment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) | Housing services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) | Educational Services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| g) | Substance misuse prevention and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| h) | Medical and dental services | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| i) | Support services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| j) | Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| k) | Services for persons with co-occurring M/SUDs | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Please describe as needed (for example, best practices, service needs, concerns, etc)

3. Describe your state's case management services

The arrangement and coordination of an individual's treatment and rehabilitation needs, as well as other medical, social, and educational services and supports; coordination of services and support activities; monitoring of services and support activities to assess the implementation of the client's individualized plan and progress towards outcomes specified in the plan; escorting clients to services when necessary to achieve desired outcomes or to access services; and direct assistance to the child, family, adult including coaching and modeling of specific behaviors and responses (the direct assistance may not involve individual or family counseling or psychotherapy).

4. Describe activities intended to reduce hospitalizations and hospital stays.

Activities designed to reduce hospitalizations include illness management, crisis prevention and wellness coaching interventions that are individualized to each person's situation. Intensive services are wrapped around individuals who have been less successful in community living such as services provided in the home that assist with daily living and symptom management. Additional activities include:

- 1) Expansion of the State Emergency Room Enhancement program to include children and youth is currently in development, with specific goal of reduction of acute hospitalization for children and youth.
- 2) Expansion of ACT-TAY teams
- 3) Continue promotion of collaboration and implementation of effective community-based interventions and supports.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.4%	
2.Children with SED	7.0%	

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

State estimates for serious mental illness (SMI) (adults) and serious emotional disturbances (SED) (children) are obtained from estimates published in the federal register (FR Doc. 98-19071; FR Doc. 99-15377). Based on these historically reported estimates required for use in the Block Grant State Plan, approximately 5.4 percent of the Missouri adult population has an SMI and 7 percent of Missouri children have an SED. The state uses prevalence data to track penetration.

Missouri does not have estimates on incidence for SMI or SED.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

- | | | |
|-----------|--|---|
| a) | Social Services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) | Educational services, including services provided under IDE | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) | Juvenile justice services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) | Substance misuse preventiion and SUD treatment services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| e) | Health and mental health services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) | Establishes defined geographic area for the provision of services of such system | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

The State of Missouri is divided into service areas some of which include rural areas. Providers established a number of service sites within these service areas in an effort to efficiently and effectively serve individuals in rural areas. Additionally, staff drive to individuals homes to provide services when individuals are not able to come to service sites. The Division of Behavioral Health supports Projects for Assistance in Transition from Homelessness (PATH) programs which supports services to individuals who have mental illness or substance use disorders who are homeless or at risk of being homeless. Older adults are included within our normal service system.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The State of Missouri receives annual State of Missouri allocations to fund provider organizations in the delivery of mental health services. Provider organizations identified as Administrative Agents receive allocations to support the uninsured, underinsured as well as Medicaid-insured Missourians while the Affiliate organizations do not receive allocations to serve uninsured or underinsured; rather, they are limited to those individuals with Medicaid. The match dollars for the Medicaid is provided via the State of Missouri for all provider organizations. Provider organizations are encouraged to pursue grant funding's and to participate in Department driven funding opportunities. Provider organizations are required to staff programs with qualified staff for each service type. Provider organizations are required to ensure staff receive the necessary trainings to provide the service that they are delivering. Trainings are available within organizations and via the Missouri Coalition of Behavioral Health Centers for provider organizations that are members of the Coalition. The State of Missouri requires Administrative Agents to meet and deliver crisis intervention services to all citizens of Missouri by providing telephone hotline and mobile crisis services. Some organizations staff hospital emergency rooms with trained mental health professionals to assist in meeting mental health crisis needs of those presenting at hospital emergency rooms. The State of Missouri is working cooperatively with law enforcement to ensure law enforcement are trained in handling mental health emergency and crisis situations. Additionally, the State of Missouri is working with a technical college to develop a curriculum tack for mental health workers. The State of Missouri also has been working with the State Medicaid agency to expand the pool of medication service providers due to the shortage of psychiatrists in Missouri. The State of Missouri plans to continue to utilize funding to serve as many individuals as possible that are in need of mental health services and that these individuals be served by a sufficient number of adequately trained staff.

Footnotes:

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- | | |
|---------------------------------|---|
| i) Screening | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ii) Education | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iii) Brief Intervention | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| iv) Assessment | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| v) Detox (inpatient/social) | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vi) Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| vii) Intensive Outpatient | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| viii) Inpatient/Residential | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| ix) Aftercare; Recovery support | <input checked="" type="radio"/> Yes <input type="radio"/> No |

b) Are you considering any of the following:

- | | |
|---|---|
| Targeted services for veterans | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Expansion of services for: | |
| (1) Adolescents | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| (2) Other Adults | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| (3) Medication-Assisted Treatment (MAT) | <input checked="" type="radio"/> Yes <input type="radio"/> No |

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? ☒ Yes ☐ No
2. Either directly or through an arrangement with public or private non-profit entities make perinatal care available to PWWDC receiving services? ☒ Yes ☐ No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? ☒ Yes ☐ No
4. Does your state have an arrangement for ensuring the provision of required supportive services? ☒ Yes ☐ No
5. Are you considering any of the following:
 - a) Open assessment and intake scheduling ☒ Yes ☐ No
 - b) Establishment of an electronic system to identify available treatment slots ☐ Yes ☒ No
 - c) Expanded community network for supportive services and healthcare ☒ Yes ☐ No
 - d) Inclusion of recovery support services ☒ Yes ☐ No
 - e) Health navigators to assist clients with community linkages ☒ Yes ☐ No
 - f) Expanded capability for family services, relationship restoration, custody issue ☒ Yes ☐ No
 - g) Providing employment assistance ☒ Yes ☐ No
 - h) Providing transportation to and from services ☒ Yes ☐ No
 - i) Educational assistance ☒ Yes ☐ No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Department continues to provide services for pregnant women and women with dependent children. The strategies to ensure this requirement is met continues to include monitoring the number of women that are pregnant and women that are pregnant and receiving treatment through the Department's information system. Additionally, the Department continues to require providers to submit data monthly to the Department for their wait list and capacity management that identifies women that are pregnant if waiting for services. When a woman is identified as pregnant and on the waiting list, the provider is contacted and questioned about the reasoning for this woman being on the wait list. These contacts have resolved the issues identified. The monthly data reports reflecting specific services being delivered assist in identifying the amount of supportive services provided per consumer.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement ☒ Yes ☐ No
 - b) 14-120 day performance requirement with provision of interim services ☒ Yes ☐ No
 - c) Outreach activities ☒ Yes ☐ No
 - d) Syringe services programs ☐ Yes ☒ No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation ☒ Yes ☐ No
2. Are you considering any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached ☒ Yes ☐ No
 - b) Automatic reminder system associated with 14-120 day performance requirement ☐ Yes ☒ No
 - c) Use of peer recovery supports to maintain contact and support ☒ Yes ☐ No
 - d) Service expansion to specific populations (military families, veterans, adolescents, older adults) ☒ Yes ☐ No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

 The Department monitors the number of IV drug users served in substance use treatment programs through the DMH information system. Wait list and capacity data is collected to monitor priority admissions for this population. Providers are required to report wait list and capacity weekly. Data is collected and analyzed with reporting dispersed to the provider identifying IV drug users on the list. Follow-up contact with the provider occurs when such persons are identified.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ☒ Yes ☐ No
2. Are you considering any of the following:
 - a) Business agreement/MOU with primary healthcare providers ☐ Yes ☒ No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment ☐ Yes ☒ No
 - c) Established co-located SUD professionals within FQHCs ☐ Yes ☒ No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

 The Department continues to contractually require programs to develop/maintain working relationship with a healthcare provider, local health department, or other professional entity for the providence of tuberculosis testing and provide for post test counseling when tests are positive as well as provide education to the participants and their family/significant others regarding risks associated with tuberculosis. Data reports are utilized to collect information pertaining the number of individuals identified with tuberculosis and the number of individuals that have received post-test counseling.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? ☐ Yes ☐ No
2. Are you considering any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas ☐ Yes ☐ No
 - b) Establishment or expansion of tele-health and social media support services ☐ Yes ☐ No
 - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ☐ Yes ☐ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)? ☒ Yes ☐ No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ☐ Yes ☒ No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ☐ Yes ☒ No

If yes, please provide a brief description of the elements and the arrangement

Criterion 8,9&10**Syringe System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement ☒ Yes ☐ No
2. Are you considering any of the following:
 - a) Workforce development efforts to expand service access ☒ Yes ☐ No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services ☒ Yes ☐ No
 - c) Establish a peer recovery support network to assist in filling the gaps ☒ Yes ☐ No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) ☒ Yes ☐ No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations ☒ Yes ☐ No
 - f) Explore expansion of service for:
 - i) MAT ☒ Yes ☐ No
 - ii) Tele-Health ☒ Yes ☐ No
 - iii) Social Media Outreach ☐ Yes ☒ No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? ☒ Yes ☐ No
2. Are you considering any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services ☒ Yes ☐ No
 - b) Establish a program to provide trauma-informed care ☒ Yes ☐ No
 - c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education ☒ Yes ☐ No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) ☒ Yes ☐ No
2. Are you considering any of the following:
 - a) Notice to Program Beneficiaries ☒ Yes ☐ No
 - b) Develop an organized referral system to identify alternative providers ☐ Yes ☒ No
 - a) Develop a system to maintain a list of referrals made by religious organizations ☐ Yes ☒ No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? ☒ Yes ☐ No
2. Are you considering any of the following:
 - a) Review and update of screening and assessment instruments ☒ Yes ☐ No
 - b) Review of current levels of care to determine changes or additions ☒ Yes ☐ No
 - c) Identify workforce needs to expand service capabilities ☒ Yes ☐ No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background ☒ Yes ☐ No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? ☒ Yes ☐ No
2. Are you considering any of the following:
- a) Training staff and community partners on confidentiality requirements ☒ Yes ☐ No
- b) Training on responding to requests asking for acknowledgement of the presence of clients ☐ Yes ☐ No
- c) Updating written procedures which regulate and control access to records ☒ Yes ☐ No
- d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure ☒ Yes ☐ No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ☒ Yes ☐ No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

All but three providers are nationally accredited. Those accredited are not required to participate in a peer review per SAMHSA although when an agency is experiencing challenges, regardless of accreditation status, a peer review may occur as a means to provide technical assistance to the provider. There are no anticipated peer reviews for FY 2018.

3. Are you considering any of the following:
- a) Development of a quality improvement plan ☐ Yes ☒ No
- b) Establishment of policies and procedures related to independent peer review ☒ Yes ☐ No
- c) Develop long-term planning for service revision and expansion to meet the needs of specific populations ☒ Yes ☐ No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? ☒ Yes ☐ No

If YES, please identify the accreditation organization(s)

- i) ☒ Commission on the Accreditation of Rehabilitation Facilities
- ii) ☒ The Joint Commission
- iii) ☒ Other (please specify)
Council on Accreditation

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ☐ Yes ☒ No
2. Are you considering any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ☐ Yes ☒ No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ☐ Yes ☒ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state ☒ Yes ☐ No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ☒ Yes ☐ No
 - c) Performance-based accountability ☒ Yes ☐ No
 - d) Data collection and reporting requirements ☒ Yes ☐ No
2. Are you considering any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs ☐ Yes ☒ No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services ☐ Yes ☒ No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ☒ Yes ☐ No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ☐ Yes ☒ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women ☐ Yes ☒ No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis ☐ Yes ☒ No
 - b) Early Intervention Services Regarding HIV ☐ Yes ☒ No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment ☐ Yes ☒ No
 - b) Professional Development ☐ Yes ☒ No
 - c) Coordination of Various Activities and Services ☐ Yes ☒ No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? ☐ Yes ☒ No

Does the state have any activities related to this section that you would like to highlight?

None.

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁶¹ paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

61 Ibid

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ☒ Yes ☐ No
2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ☒ Yes ☐ No
3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ☒ Yes ☐ No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☒ No

5. Does the state have any activities related to this section that you would like to highlight.

While the State has plans in place for Peer Support for adults & families, they are not hired specifically for their trauma experience in developing trauma informed organizations. Activities include:

*The state is creating trauma responsive programs in forensic mental health. Training is scheduled for October 16 & 17, 2017.

*The state has already conducted six regional motivational interviewing trainings around the state and will have trained 199 individuals from 59 agencies participating from Children's Division, Child Advocacy Centers, MoHealthNet, and Department of Mental Health (including addiction providers and community mental health centers) throughout the state.

*The state has established a trauma-informed learning collaborative with 6 agency teams (each team has 5-6 team members) participating from Children's Division, Child Advocacy Centers, MoHealthNet, and Department of Mental Health.

*Children's Trauma Summit will be held in May for 299 behavioral health professionals, children's division, sexual and domestic violence shelters, homeless shelters, court personnel, and school professionals to be trained on evidenced-based practices.

*Missouri Children's Trauma Network has developed a website located at www.motcn.com to provide resources and information related to evidence-based trainings, learning collaborative, technical assistance, resources, etc. We have had numerous inquiries come through the website seeking information from both parents and behavioral health professionals.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁶²

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶³

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁶² Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csgjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ☒ Yes ☐ No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ☒ Yes ☐ No
3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ☒ Yes ☐ No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ☒ Yes ☐ No

5. Does the state have any activities related to this section that you would like to highlight?

The Department of Mental Health (DMH) is a charter member of the Missouri Reentry Process steering team that works to improve re-entry processes. Community Mental Health Liaisons have been established to assist law enforcement and the Courts in diverting individuals from emergency rooms, jails, and prison. Crisis Intervention Team (CIT) councils have been established throughout the state and CIT training is available, including an annual CIT conference. DMH participates and/or facilitates several inter-agency coordinating committees. More specifically, DMH facilitates a monthly oversight meeting with the Missouri Department of Corrections (DOC) which includes representatives for treatment and recovery. The oversight team reviews a variety of data to determine outcomes and treatment needs that will promote public safety and diversion from re-incarceration. Further, the oversight team has developed numerous programs (Early Intervention, Integrated Handoff, High Risk Offender, Community Mental Health Treatment Offenders with Serious Mental Illness) to expedite linkage of behavioral health services to individuals reentering communities. DOC and DMH have collaborated on two projects providing Medication Assisted Treatment (MAT), specifically Vivitrol, to individuals prior to their release from incarceration. Additionally, DMH participates in the Mental Health Advisory Council hosted by the Assistant Division Director of Mental Health Services for the DOC.

DMH also participates in a quarterly oversight meeting with the Office of State Courts Administrator to discuss needs and barriers for our treatment courts. DMH is a voting member of the Drug Courts Coordinating Commission, which by statute is comprised of four judicial appointments and four executive branch appointments from the Departments of Social Services, Corrections, Public Safety, and Mental Health. The commission ensures resources are available to assist treatment court participants. The commission also oversees the operations of the treatment courts.

DMH provides ongoing training on adolescent brain development, with a focus on the impact of trauma for the Missouri Juvenile Justice Association Fundamental Skills curriculum offered statewide. DMH, the Department of Social Services, and the Juvenile Courts established a collaborative protocol for the three child serving agencies to be able to divert youth from entering or remaining in state custody solely to accessing mental health services. DMH provided training at the 2016 and 2017 Missouri Juvenile Justice Association Conferences to professionals working with or in the juvenile justice system on understanding and utilizing the Custody Diversion Protocol.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ☒ Yes ☐ No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women? ☒ Yes ☐ No
3. Does the state purchase any of the following medication with block grant funds? ☒ Yes ☐ No
 - a) ☒ Methadone
 - b) ☒ Buprenorphine, Buprenorphine/naloxone
 - c) ☒ Disulfiram
 - d) ☒ Acamprosate
 - e) ☒ Naltrexone (oral, IM)
 - f) ☐ Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately? ☒ Yes ☐ No
5. Does the state have any activities related to this section that you would like to highlight?

DBH contracted providers are required to make available, either through direct prescribing or via referral arrangements, all FDA approved medications for the treatment of AUD and OUD. DBH contracted providers also able to provide medication services via telehealth, which allows for increased access to MAT for consumers in all areas of the state.

Please indicate areas of technical assistance needed to this section.

N/A

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- a) ☒ Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) ☐ Psychiatric Advance Directives
- c) ☒ Family Engagement
- d) ☒ Safety Planning
- e) ☒ Peer-Operated Warm Lines
- f) ☐ Peer-Run Crisis Respite Programs
- g) ☒ Suicide Prevention

2. Crisis Intervention/Stabilization

- a) ☒ Assessment/Triage (Living Room Model)
- b) ☒ Open Dialogue
- c) ☒ Crisis Residential/Respite
- d) ☒ Crisis Intervention Team/Law Enforcement
- e) ☒ Mobile Crisis Outreach
- f) ☒ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) ☒ WRAP Post-Crisis
- b) ☒ Peer Support/Peer Bridges
- c) ☒ Follow-up Outreach and Support
- d) ☒ Family to Family Engagement

- e) ☒ Connection to care coordination and follow-up clinical care for individuals in crisis
- f) ☒ Follow-up crisis engagement with families and involved community members
- g) ☒ Recovery community coaches/peer recovery coaches
- h) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Missouri began the Emergency Room Enhancement (ERE) program in FY13, which connected hospitals and emergency rooms with staff from their area mental health center. We began in FY13 with ERE programs in seven regions of the state. This FY, FY18, we are adding an additional five ERE programs to cover more areas of the state. The ERE programs have shown to reduce ER and hospital usage, decrease homelessness and contact with law enforcement, and increase employment for individuals engaged at three and six months post enrollment.

Please indicate areas of technical assistance needed to this section.

N/A

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? ☒ Yes ☐ No
- b) Required peer accreditation or certification? ☒ Yes ☐ No
- c) Block grant funding of recovery support services. ☒ Yes ☐ No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
Yes

2. Does the state measure the impact of your consumer and recovery community outreach activity? ☐ Yes ☒ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

- Clubhouses
- Drop-in centers
- Peer specialist
- Peer wellness coaching
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Room and board when receiving treatment

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

- Recovery community centers (new service with Opioid STR grant)
- Peer recovery coaching
- Peer wellness coaching
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Telephone recovery checkups (new service with Opioid STR grant)
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Person-centered planning
- Self-care and wellness approaches
- Room and board when receiving treatment

5. Does the state have any activities that it would like to highlight?

"Recovery, wellness, and community inclusion" remain an ongoing focus in the Department of Mental Health's 2013-2018 Strategic Plan (DMH, 2012).

Peer Support: Peer support services are available to individuals in behavioral health treatment. These services are face-to-face services or group services with a rehabilitation and recovery focus. Peer Specialists can share lived experiences of recovery, share and support use of recovery tools, and model successful recovery behaviors.

Peer support services are Medicaid-reimbursable for mental health treatment. Missouri currently has 529 peer specialists (298

Family Support: Family support is a peer support service provided to parents and caregivers of children, youth, and young adults (18-25). Trained Family Support Specialists with lived experience provide individualized, one-on-one supports and services to the parents or caregivers. This may include providing information and resources to help the family better understand what is happening with their child. They also provide support to help the parents or caregivers develop problem-solving strategies and assistance in navigating the service system. In FY 2016, 922 families received family support services.

DMH's Consumer-Operated Services Programs (COSPS) are peer-run service programs that are administratively controlled and operated by mental health consumers and emphasize self-help as their operational approach. DMH funds five Drop-In Centers that provide a safe place where consumers can go to find recovery programs and services provided by their peers. DMH also funds five warm lines that provide safe, confidential telephone support provided by peers in recovery for assistance with non-crisis mental health issues.

Employment: DMH works to integrate clinical and vocational supported employment services through statewide partnerships with the Office of Adult Learning & Rehabilitation Services (Vocational Rehabilitation – VR) and provider agencies. The goal is to help individuals who are interested in employment participate in the competitive labor market in a job of their preference with the appropriate level of professional help needed to be successful. DMH has 11 community treatment providers designated as VR funded Community Rehabilitation Programs to provide supported employment services. Technical assistance, training, and fidelity reviews are conducted to ensure fidelity to the model. DMH supports the usage of Disability Benefits 101, which is a Missouri specific online tool designed to provide information on health coverage, benefits, and employment. The tool also provides information for veterans and youth interested in higher education.

Wellness: DBH has provided and will continue to provide training on WRAP, WHAM, and Wellness Coaching on the Eight Dimensions of Wellness. DBH continues to provide the wellness training based on Peggy Swarbrick's Collaborative Support Programs of New Jersey (CSP-NJ) and the University of Medicine and Dentistry of New Jersey, School of Health Related Professions, Department of Psychiatric Rehabilitation and Counseling Professions train-the-trainers model.

Department of Mental Health (2012). Strategic Directions 2013-2018. Retrieved at: <http://dmh.mo.gov/docs/opla/DMHStrategicDirections2013-2018.pdf>.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :
 - housing services provided. ☒ Yes ☐ No
 - home and community based services. ☒ Yes ☐ No
 - peer support services. ☒ Yes ☐ No
 - employment services. ☒ Yes ☐ No
2. Does the state have a plan to transition individuals from hospital to community settings? ☒ Yes ☐ No
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Governor's Council on Disability (GCD) is committed to advancing Missouri's compliance with the Supreme Court decision in Olmstead vs. L.C. The Council provides staff and resources to support this vital effort. The mission of the Council is to provide leadership and support so people with disabilities achieve inclusion and independence. The GCD Resource Director is available at: http://disability.mo.gov/resource_search/. The Division of Behavioral Health (DBH) keeps informed and current with the Governor's Council's actions. DBH has numerous programs, services and evidence based practices that promote compliance with the Olmstead Decision. The Missouri DBH has encouraged the Community Mental Health provider system to reach beyond psychiatric diagnoses by developing Disease Management programs, providing outreach to people with serious health/mental health/substance use disorders who are high utilizers of Medicaid, coordinating services with consumer's primary care physicians, conducting metabolic screenings for consumers, and providing education about health and safety. The DBH has Individual Placement and Support (IPS) employment services sites, and works with the State Department of Elementary and Secondary Education (DESE) to provide vocational rehabilitation services to DBH consumers. DBH works with community providers to build, access and/or fund appropriate housing for each individual. Housing options across the state range from Housing First programs to Residential Care facilities with specialized Psychiatric Independent Supported Living homes, clustered apartments, safe havens, Intensive Residential Treatment Settings (IRTS), Assertive Community Treatment (ACT) teams for people living independently in the community who need additional supports or Supported Community Living dollars to help people live in the setting of their choice. Other funding options include Shelter + Care, Rent Assistance Program, Section 8 Housing and assistance with the application process.

Does the state have any activities related to this section that you would like to highlight?

None.

Please indicate areas of technical assistance needed related to this section.

None.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community⁶⁶. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24⁶⁷. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death⁶⁸.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21⁶⁹. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁸Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMH12010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
 - a) The recovery and resilience of children and youth with SED? ☒ Yes ☐ No
 - b) The recovery and resilience of children and youth with SUD? ☒ Yes ☐ No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - a) Child welfare? ☒ Yes ☐ No
 - b) Juvenile justice? ☒ Yes ☐ No
 - c) Education? ☒ Yes ☐ No
3. Does the state monitor its progress and effectiveness, around:
 - a) Service utilization? ☒ Yes ☐ No
 - b) Costs? ☒ Yes ☐ No
 - c) Outcomes for children and youth services? ☒ Yes ☐ No
4. Does the state provide training in evidence-based:
 - a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ☒ Yes ☐ No
 - b) Mental health treatment and recovery services for children/adolescents and their families? ☒ Yes ☐ No
5. Does the state have plans for transitioning children and youth receiving services:
 - a) to the adult behavioral health system? ☒ Yes ☐ No
 - b) for youth in foster care? ☒ Yes ☐ No
6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The systems of care approach recognizes the importance of family, school, and community and in which services are provided through a comprehensive, seamless system. Both substance use disorder and mental health services for children are coordinated under the Division of Behavioral Health (DBH). Additionally, the Division of Behavioral Health (DBH) worked with MoHealthNet (MHN) to change the age range requirements for specific Medicaid services. In many cases, the emerging young adult is in need of services from both systems at the same time. Services are not duplicative, but simply that the services wrapped around the young adult are individualized and able to meet their clinical needs for their developmental age. Providers have the ability to simultaneously access access funds from their children and adult allocations to pay for the individualized services depending on which funding stream makes the most sense for payment.
7. Does the state have any activities related to this section that you would like to highlight?

The state of Missouri currently has 20 formalized system of care teams throughout the state. In addition, there are also two federally funded system of care grant programs currently in operation, SOC-CESS and the System of Care, St. Louis Region for the enhancement and expansion of the system of care values and principles throughout the state.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ☐ Yes ☒ No

2. Describe activities intended to reduce incidents of suicide in your state.

Grant

The Show Me Zero Youth Suicide Initiative aims to reduce youth suicide through an integrated systems-level approach, which includes establishing a continuity of care model for youth at risk of suicide and promoting the adoption of suicide prevention as a core priority of youth-serving institutions, such as hospitals and schools. Through collaboration with these organizations, this initiative is effectively identifying youth ages 10-24 who are at risk for suicide and providing them immediate linkage to intensive services and follow-up care.

Services are being focused on a five-county region in western Missouri, centered on Jackson County, which includes Kansas City, as well as surrounding counties with more rural areas.

The overall aim of the Show Me Zero Youth Suicide Initiative is to reduce suicides and suicide attempts by accomplishing three major goals:

- 1) Improve the system of care of suicidal youth who use hospital emergency departments, in-patient psychiatric facilities, and/or crisis hotlines.
- 2) Improve the capacity of school systems to identify, respond, and refer youth at risk of suicide.
- 3) Strengthen overall prevention efforts for at-risk youth populations in other settings.

Signs of Suicide (SOS) Training

DMH contracted Prevention Resource Center (PRC) staff have been trained as SOS Trainers. The PRC's provide this training to school staff across the state.

Zero Suicide Initiative

The Coalition for Community Behavioral Healthcare, in collaboration with DMH and the national Suicide Prevention Resource Center, has hosted a Show Me Zero Suicide Learning Collaborative for Community Mental Health Centers the last two years with another one planned next year. DMH facilities are also being educated on the Zero Suicide framework.

Suicide Prevention Campaign

DMH has implemented a suicide prevention campaign targeting middle-aged men in rural areas, using radio ads, billboards, and fact sheets to educate individuals and their loved ones on warning signs of suicide and how to get help.

3. Have you incorporated any strategies supportive of Zero Suicide? ☒ Yes ☐ No
4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ☒ Yes ☐ No
5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? ☒ Yes ☐ No

If so, please describe the population targeted.

The Show Me Zero Youth Suicide Initiative targets youth ages 10-24 who are at risk for suicide. Signs of Suicide (SOS) training trains school faculty and staff to respond to suicide risks in middle school and high school. The Zero Suicide Initiative targets the state's behavioral health provider network. The Suicide Prevention Campaign targets middle-aged men in rural areas.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ☒ Yes ☐ No
2. Has your state identified the need to develop new partnerships that you did not have in place? ☒ Yes ☐ No

If yes, with whom?

Children's Services:

As a result feedback from community partners and local mental health boards and needs assessments, Missouri has entered into multiple new partnerships to address mental health needs: 1) Systems of Care Teams encourage new partnerships through community outreach and social media. 2) Veterans Administration and community-based veterans service groups; 3) collaborative agreements with the juvenile justice system for mental health services; and 4) Creating new partnerships with schools and community-based service providers for the provision of mental health services in schools.

Adult Services:

The Division of Behavioral Health (DBH) has developed new partnerships with the Missouri Nurses Association, the Department of Health and Senior Services, and the Missouri Hospital Association.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Children's Services:

The System of Care Teams (SOC) meet regularly to coordinate efforts and to ensure alignment with local community partners. Missouri is one of 24 states to receive a Planning Grant from SAMHSA to prepare for implementing a federal demonstration project designed to pilot a Prospective Payment System for community behavioral health systems. Additionally, Missouri developed

the Emergency Room Enhancement initiative (ERE) in response to large numbers of individuals seeking help for behavioral health concerns in hospital emergency room. ERE goals are to prevent repeated ED visits and hospitalizations as well as increase the rate of housing, employment and education enrollment. There are currently 7 ERE sites with plan to add three additional sites in September 2017.

Adult Services:

The DBH continuously works with other state entities to collaborate on initiatives and provide education in an effort to reduce costs, maximize efficiency and quality of services, and improve outcomes. Regular meetings are held with the Department of Corrections (DOC), the Office of State Court Administrators, Department of Social Services (DSS), the DHSS, and the Missouri Primary Care Association.

Does the state have any activities related to this section that you would like to highlight?

Children's Services:

Missouri has two SAMHSA funded grants: 1) SOC-CESS which focuses on First Episode Psychosis and 2) System of Care (SOC), St. Louis Region, which focuses on the expansion of SOC principles.

Adult Services:

The DBH works with the DSS MO HealthNet Division (MHD), the state Medicaid authority, on several initiatives including the Disease Management initiatives, Health Homes, the Behavior Pharmacy Management, and the Opioid Pharmacy Intervention programs. All of these collaborations with MHD include cross sharing of data, joint program management, and better outcomes for the individuals served. The DBH and DOC has collaborated to create several programs that expedite the linkage of behavioral health services to individuals returning to the community from the DOC institutions. These include, but are not limited to, the Early Intervention program, Integrated Handoff project, High Risk Offender program, Community Mental Health Treatment program, Offenders with Serious Mental Illness program, and two Vivitrol Pre-release projects.

Please indicate areas of technical assistance needed related to this section.

N/A

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration**.⁷²

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
 - a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Missouri has two separate planning councils: State Advisory Council on Alcohol and Drug Abuse (SAC-ADA) and a State Advisory Council on Comprehensive Psychiatric Services (SAC-CPS). Missouri's planning council for alcohol and drug (ADA) programs is comprised of 25 members including service providers, consumers (recipients of services or family members of recipients), and other interested citizens. At least one-half of the members shall be consumers, and one member shall represent veterans and military affairs. No more than one-fourth of the members shall be vendors or members of boards of directors, employees or officers of vendors, or spouses of any of the above mentioned, if such vendors received more than fifteen hundred dollars (\$1,500) per year under contract with the Department of Mental Health. Members of boards of directors of not-for-profit corporations shall not be considered vendors. Each member shall be appointed for an initial term of one, two, or three years to allow for a rotation of one-third of the members each year. Further, each appointed member may be re-appointed to no more than one additional three-year term. Each member serves until a successor has been appointed. The functions and duties of the planning council for ADA shall be to:

 - 1) Promote meetings and programs for the discussion of reducing the debilitating effects of alcohol or drug use and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation for persons affected by alcohol or drug use;
 - 2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and its resources in the provision of services to persons affected by alcohol or drug use through private and public residential facilities, day programs and other specialized services;
 - 3) Recommend what specific methods, means and procedures should be adopted to improve and upgrade the alcohol and drug use service delivery system for citizens of this state;
 - 4) Participate in developing and disseminating criteria and standards to qualify alcohol and drug use residential facilities, day programs and other specialized services in this state for funding by the department (RSMO 631.020).

Most members of the ADA planning council have leadership roles as managers, advocates or volunteers in the substance use service delivery system. Current representation includes consumers; treatment, recovery support, and prevention service providers; Department of Corrections; Department of Health and Senior Services; and the Veteran's Administration.
 - b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i ☒ Yes ☐ No
2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ☒ Yes ☐ No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Missouri has two separate planning councils: State Advisory Council on Alcohol and Drug Abuse (SAC-ADA) and a State Advisory Council on Comprehensive Psychiatric Services (SAC-CPS). The SACs meet every other month. The morning session is held jointly and the afternoon session is held separately.

As specified in state statute, the functions and duties of the SAC-ADA are to:

- 1) Promote meetings and programs for the discussion of reducing the debilitating effects of alcohol or drug use and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation for persons affected by alcohol or drug use;
- 2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and its resources in the provision of services to persons affected by alcohol or drug use through private and public residential facilities, day programs and other specialized services;
- 3) Recommend what specific methods, means and procedures should be adopted to improve and upgrade the alcohol and drug use service delivery system for citizens of this state;
- 4) Participate in developing and disseminating criteria and standards to qualify alcohol and drug use residential facilities, day programs and other specialized services in this state for funding by the department (RSMO 631.020).

The SAC-ADA provides a diverse perspective on the prevention and treatment of substance use. SAC-ADA meetings include updates, presentations, and discussions from the Division of Behavioral Health (DBH) Director and/or his representative and section heads from prevention, treatment, and fiscal units. In addition, the SAC-ADA receives regular briefings and feedback from the Missouri Recovery Network, which is a statewide organization advocating for addiction treatment and recovery support. Membership includes individuals in recovery, family members, friends, allies, and other supportive people. The SAC-ADA also receives regular briefings from the Missouri Substance Abuse Professional Credentialing Board on matters pertaining to professional credentialing and workforce development. The SAC-ADA meets in joint sessions with the SAC-CPS as needed to coordinate recommendations on behavioral health services, including recommendations for Missouri's FY 2016-2017 Behavioral Health Assessment and Plan.

The SAC-CPS has the following duties:

- 1) Review State plans and submit any recommended modifications to DBH;
- 2) Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems;
- 3) Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

The SAC-CPS serves as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems. SAC-CPS advocacy activities include promoting the Consumer/Family/Youth Conference; Peer Specialist training and certification; and coordinating Hands across Missouri – an annual, consumer-run event sponsored by the SAC-CPS, the Missouri Mental Health Foundation, and local organizations. The SAC-CPS continues to support Peer Specialist training and certification. Through this process, consumers can learn to identify their strengths and personal resources, learn to make independent choices, and take a proactive role in their treatment.

Real Voices Real Choices is the annual consumer conference to educate, inform, and empower individuals in treatment and/or recovery and their families. This conference developed from Missouri's Mental Health Transformation Grant, a SAMHSA-funded grant that ended in 2011. The 2016 Conference was held in August at Lake of the Ozarks. The SAC-CPS has a subcommittee who plans and coordinates this conference.

Both the SAC-ADA and the SAC-CPS promote the Missouri's Mental Health Champions – an effort to recognize the accomplishments of individuals whose lives have been challenged by mental illness, substance use disorders, and/or developmental disabilities. The 2017 Mental Health Champion awards ceremony and banquet was held in June at the Capitol Plaza Hotel in Jefferson City.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

N/A

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.⁷³

⁷³There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

**Division of Behavioral Health
State Advisory Councils
Meeting Minutes
December 7, 2016**

Members Present: Daniel Cayou, Sarah Earll, Liz Hagar-Mace, Rebecca Maynard, Toni Jordan, Mickie McDowell, Page Nichols, Carrie Rigdon, Barb Scheidegger, Amy Stevens, Christine McDonald, Liz Page, Angela Reynolds, Randall Robb, Mark Smith, David Stoecker, Karah Waddle, Janet Worthy and Malva Yocco

Members Absent: Bruce Charles, Amanda Dumey, Eric Martin, Denise Mills, Linda Myers, Susan Scott, Mindy Ulstad, Sean Adams, John Czuba, Kathi Grose, Jean Sokora, Sandra Jackson, Nancy Johnson, Richard Kenney, Karen Leydens-Martin, Hugh Scott and Stephanie Washington

Department of Mental Health/Division of Behavioral Health (DMH/DBH) Staff: Dr. Christie Lundy, Dr. Robert Reitz, Lexy Thompson, Rosie Anderson-Harper, Dr. Rick Gowdy, Amanda Baker, Jessica Bounds, Laurie Epple, Stacey Williams, Debbie McBaine, Vickie Epple, Melissa Smyser, Angie Stuckenschneider, Nora Bock, Connie Cahalan, Jon Sabala, Susan Blume, Vicki Schollmeyer, Tim Rudder and Susan Leonard

Guests: John Hudgens, Scott Johnston, Dr. Angeline Stanislaus, Brenda Schell and Elizabeth Brown

TOPIC/ISSUE	DISCUSSION	ACTION/PENDING Responsible Due Date
<p>Call To Order</p> <p>Division Director Update/Discussion</p>	<p>Chairperson, Sarah Earll, called the meeting to order. Self-introductions were made.</p> <p>Dr. Richard Gowdy, Division Director</p> <p>Updated two pending initiatives: The Mental Health Crisis Prevention Project (MHCPP), also known as the 1115 Waiver; and the Certified Community Behavioral Health Clinic (CCBHC) two-year demonstration project, also known as the Excellence in Mental Health Act.</p> <p>Updated Director's Ambassador Academy trainings, held the past three years at the State Capitol. These presentations have been very well received and are successful in helping people understand what we do and why it is important. Next year we plan to present on children's issues across behavioral health and developmental disabilities.</p> <p>At a meeting with members of the Governor-Elect's Transition Team, we presented our budget items (only mandatory items this year). Given the \$200-300 million dollar shortfall we are looking at, our list of high-priority items may not receive consideration.</p>	

TOPIC/ISSUE	DISCUSSION	ACTION/PENDING Responsible Due Date
<p>Budget Update</p> <p>Approval of Minutes</p> <p>Fulton State Hospital Update</p>	<p>At another meeting with members of the Governor-Elect's Transition Team, we gave an overview of the services DMH provides. We stressed to the team that the people we serve have multiple needs and if we are unable to provide appropriate services up front, many of these people will have crises or other issues resulting in their contact with law enforcement, hospital emergency rooms or other systems, a financial cost that does not result in a better outcome. However, if money is spent on treatment and prevention, better outcomes result. We really are a safety net provider and a provider of last resort and our dollars are very important for individuals with developmental disabilities and mental health and substance use disorders.</p> <p>Laurie Eppe, Deputy Director of Administration</p> <p>We started the year off \$170 million below the Consensus Revenue Estimate and are now looking at a \$200-300 million shortfall for Governor-Elect Greitens. This may mean further restrictions for fiscal year (FY) 2017.</p> <p>Our budget is in. Budget and Planning is working with the Senate and House this week to complete the new Consensus Revenue Estimate.</p> <p>We believe the State of the State will take place toward the end of January 2017. At that time, the governor's recommended budget will come out.</p> <p>A motion was made by Karah Waddle to approve the minutes as written for the ADA State Advisory Council (SAC) meeting of October 26, 2016. The motion was seconded by Malva Yocco. The October 26, 2016 meeting minutes were approved as written.</p> <p>A motion was made by Liz Hagar-Mace to approve the minutes as written for the CPS SAC meeting of October 27, 2016. The motion was seconded by Toni Jordan. The October 27, 2016 meeting minutes were approved as written.</p> <p>Dr. Robert Reitz, Department of Mental Health</p> <p>Provided update on the design and construction of a new Fulton State Hospital in Fulton, Missouri. The new, modern 300-bed high security forensic psychiatric hospital will combine maximum and intermediate security psychiatric beds for patients, while addressing the need for public safety and will have staffing advantages that will allow us to make sure people get</p>	

TOPIC/ISSUE	DISCUSSION	ACTION/PENDING Responsible Due Date
<p>Block Grant Overview</p> <p>Membership Update</p> <p>Integration Steering Committee Introduction and Overview</p>	<p>the treatment they need when they need it. Infrastructure to support an additional 260 beds within existing buildings will be created. In addition, the new facility will house departments necessary to operate the hospital. Construction began in Spring 2015 with demolition of existing buildings and is to be completed by Fall 2018 at a total cost of \$211 million. Project remains within budget and on time.</p> <p>Dr. Christie Lundy, State Planner, Department of Mental Health</p> <p>Provided overview on draft of Missouri Division of Behavioral Health State Plan – FY 2018-2019 Substance Abuse Prevention and Treatment (SAPT) Block Grant. The block grants represent a significant source of funding for the Division of Behavioral Health. The Mental Health Block Grant (MHBG) is about \$8.5 million. The Substance Abuse Prevention and Treatment Block Grant is \$26.5 million. Our block grant state plan combines both mental health and substance use, which makes sense since we have integrated our divisions. This plan describes our behavioral health system, not just block grant funded programs. In early February, a second draft of the Plan will be sent out and posted to the DMH website for a 30-day period for public comment. The final draft will be submitted to the DBH director for his approval then submitted to Substance Abuse and Mental Health Services Administration (SAMHSA) by September 1, 2017.</p> <p>On behalf of the Department of Mental Health, Division of Behavioral Health, Mickie McDowell was awarded a plaque for six years of dedicated service (2010-2016) as a member of the Comprehensive Psychiatric Services State Advisory Council. Mickie's term ended November 2016.</p> <p>John Hudgens, Advocates for Human Potential (AHP) Scott, Johnston, Missouri Department of Mental Health</p> <p>Provided overview of the process for Division of Behavioral Health State Advisory Councils' integration planning history for the purpose of building a strategic plan for integration. The Integration Steering Committee, made up of members from each SAC, requested AHP facilitate identical processes with each SAC for clear representation of separate membership's perspectives, analyzed each council's findings and formed recommendations. Today the Integration Steering Committee will report their findings and recommendations for integration to each council for consideration.</p>	<p>After review of the Plan, State Advisory Council members may email their comments to Lexy Thompson and she will forward to Dr. Lundy.</p>

TOPIC/ISSUE	DISCUSSION	ACTION/PENDING Responsible Due Date
<p>Integration Options and Committee Recommendations</p>	<p>While assisting with AHP facilitations, Scott observed a very engaged steering committee and process. The committee was successful in engaging members from both councils in the process. They heard and listened to genuine concerns and a little hesitation from some SAC members about losing their voice in the process. There was official and unofficial recognition of those concerns by DMH/DBH and the steering committee in the way the process was handled. And while there is real interest from DMH/DBH that the councils move forward with the reorganizations that have occurred in the department and in the field, there was a strong desire that this process be SAC driven and guided and that the councils be empowered to the results of this process.</p> <p>David Stoecker, ADA SAC, Integration Steering Committee Representative Barb Scheidegger, CPS SAC, Integration Steering Committee Representative</p> <p>The State Advisory Council Integration Steering Committee provided the councils with their recommendations for integration. Common themes and considerations were presented. The committee outlined the following three options for the councils to vote on.</p> <p>Option 1:</p> <ul style="list-style-type: none"> • No change to basic council operations. • Councils will remain separate bodies. • Each council will continue to meet separately every other month. • Councils will form subcommittees to work on projects of mutual interest identified in the SWOTS including: <ol style="list-style-type: none"> 1) Creating an orientation and education process for new council members for both councils. 2) Creating a process to better measure and share outcomes for council efforts and success. 3) Identifying and deploying ways to focus on services and needs for children and families. <p>Option 2:</p> <ul style="list-style-type: none"> • Councils will merge to become one body. • Merged council will meet monthly. • Councils will form subcommittees to work on areas identified in the SWOTS as noted in option 1. <p>Option 3: *endorsed by the integration steering committee*</p>	

TOPIC/ISSUE	DISCUSSION	ACTION/PENDING Responsible Due Date
<p>Addiction Medicine Education for Doctors in Missouri</p>	<ul style="list-style-type: none"> Children and Families: Barb Scheidegger, Malva Yocco and Amy Stevens. <p>David Stoecker and Sarah Earll will be available to assist subcommittees.</p> <p>John Hudgens and Scott Johnston have access to tools useful to subcommittees.</p> <p>Rosie Anderson-Harper indicated there is a national group that does planning councils whose materials we can use.</p> <p>Scott Johnston said it makes sense for the Integration Steering Committee to respond to the questions raised regarding Option 3 and its implementation (See Integration Options – Questions and Discussion).</p> <p>Dr. Angeline Stanislaus, Chief Medical Director – Adult Services</p> <p>Provided information on the implementation of Medication-Assisted Treatment (MAT) for opioid use and maximizing its impact across Missouri.</p> <p>The American Academy of Addiction Psychiatry (AAAP) received a grant from SAMHSA to train physicians in the treatment of opioid addiction so they can obtain a Suboxone waiver and prescribe Suboxone, a controlled substance, to their patients. To do this, doctors must complete an 8-hour specific training through the Drug Addiction Treatment Act of 2000 (DATA 2000). Training will take place in several locations throughout Missouri in Spring 2017. Having more physicians (psychiatrists, family care, internal medicine and specialized physicians) trained and certified to prescribe Suboxone will benefit individuals with opioid addiction. However, prescribing Suboxone alone is not the answer. The treatment team must understand opioid addiction and provide additional supportive therapies. Once physicians receive the training and waiver, we must assist Community Mental Health Clinics in developing opioid treatment programs, which include supportive therapies and also address any mental health and/or medical issues that may be present.</p> <p>We are working with University of Missouri – Kansas City (UMKC) to develop an Addiction Psychiatry Fellowship Program for psychiatrists and also fellowship programs through universities for internal medicine and family practice physicians, pain specialists and other</p>	<p>Lexy will email council members, asking if they would like to serve on subcommittee and discuss next steps with subcommittee members.</p> <p>Rosie would like to request SAMHSA have John Hudgens continue to be involved with us to provide resources useful to subcommittees.</p> <p>For physicians interested in a non-psychiatry fellowship program, contact Rosie Anderson-Harper.</p>

TOPIC/ISSUE	DISCUSSION	ACTION/PENDING Responsible Due Date
	<p>providers who work in the realm of opioid addiction. St. Louis University is also developing an Addiction Medicine Fellowship for general practitioners, internal medicine and other physicians.</p> <p>Another project in the works for early 2017 is to speak with Missouri universities regarding the development of core curriculums for substance addiction for students in the medical field/residency programs.</p> <p>Dr. Stanislaus opened the floor to questions and discussion upon which the following consensuses were made:</p> <ul style="list-style-type: none"> • Treatment with Suboxone is a patient-specific mode of treatment. It may not be appropriate for everyone with an opioid addiction. • Medication-assisted treatment must be accompanied by supportive therapies for long-term effectiveness. It is stressed in training not to prescribe Suboxone without support services. The medical community, patients and their families need to be well educated on all options in the treatment of opioid addiction so they can make an informed decision regarding individualized treatment specific to the patient. • After physicians are certified it is our job to help develop guidelines for treatment. • The success rate of Suboxone treatment depends on how you define success. In addition to preventing accidental death, to many individuals addicted to opioids, success is maintaining a home and job while taking care of themselves and their families. If they have to receive long-term treatment with Suboxone or other addiction medication to live a normal life, it is well worth it. At the end of the day, it is about living and having a good quality of life. • Long-term use of addiction medications should not be viewed any differently than long-term use of medications for other chronic conditions such as diabetes and heart disease. Medications help people with chronic medical conditions live successful lives and addiction medication can also help people with opioid addiction live successful lives. • The medical model needs to start looking at risk reduction, not cure. Cure would be ideal and for some it is there. They should be given the option for cure and not told they cannot be cured. There are people that can be cured and if you intervene early enough, hopefully you will have a cure. Most of the people we see have not had early intervention. These are men and women who are in their 30s and 40s by the time they come in. Many have lost everything. 	

TOPIC/ISSUE	DISCUSSION	ACTION/PENDING Responsible Due Date
<p>Adjourn</p>	<ul style="list-style-type: none"> • The medical profession was not ready. We failed our people by not intervening and by believing that if they wanted to change they could do it on their own. We need to provide the support they need in order for them to develop a sense of control so they can plan and have a life. • It is critically important for the therapeutic community to hear the success stories of individuals that have been treated or are in treatment for opioid addiction. • For the individual treated for opioid addiction, it is important to replace the thing that consumed their life and time with something healthy and fulfilling because when you take anything out of your life, you have to put something back in, otherwise the void will be filled with old habits. Medications help the most extreme mental health and substance use disorders so the individual can function, but when they find meaning in life, that is when you see life in their eyes, they become bright and you see them smile again. • At the end of the day, as a psychiatrist, doctor, therapist, or social worker, all we can do is help give people hope and find purpose for their life. That is the common goal. <p>Christine McDonald made a motion to adjourn. Toni Jordan seconded the motion. Meeting adjourned.</p> <p>The DBH State Advisory Councils' next meeting is scheduled for Thursday, January 5, 2017.</p>	

ERIC R. GREITENS
GOVERNOR



MARK STRINGER
DIRECTOR

RICHARD N. GOWDY, PH.D.
DIRECTOR
DIVISION OF
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August 2, 2017

Grants Management Officer
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Rd, Room 7-1091
Rockville, MO 20850

Dear Grants Management Officer:

The State Advisory Councils for the Missouri Department of Mental Health, Division of Behavioral Health (DBH), (formerly the Division of Comprehensive Psychiatric Services and the Division of Alcohol and Drug Abuse) have reviewed the state's FY2018 – 2019 Behavioral Health Block Grant State Plan – which combines plans for both mental health and substance use disorders. Both State Advisory Councils are committed to working with the DBH to create a well-integrated system of care that implements evidence-based practices and incorporates a focus on recovery. In December 2016, the State Advisory Councils held a joint meeting to assist DBH in developing the Behavioral Health Block Grant State Plan. Both Councils have reviewed and approve of Missouri's final State Plan, written under our guidance.

We will continue to work with the DBH in monitoring the implementation of the State Plan. We appreciate our involvement in the Block Grant planning development and would like to express appreciation to SAMHSA for making these funds available.

Sincerely,

Handwritten signature of Sarah A. Earll in black ink.

Sarah Earll, Chair
CPS State Advisory Council

Handwritten signature of Sandra Jackson in black ink.

Sandra Jackson, Chair
ADA State Advisory Council

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Sean Adams	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1505 Little Ave, Apt 4 Grandview MO, 64030 PH: 816-830-8943	adams.sean12@yahoo.com
Daniel Cayou	Providers	Missouri Protection & Advocacy	925 South Country Club Jefferson City MO, 65109 PH: 573-893-3333	Daniel.Cayou@mo-pa.org
Amanda Dumey	Family Members of Individuals in Recovery (to include family members of adults with SMI)		809 N Campbell Ave Springfield MO, 65802 PH: 417-881-1397	amanda.dumey@isosm.org
Sarah Earll	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	St. Louis Empowerment Center	1908 Olive St Louis MO, 63103 PH: 314-652-6103	ssearll@sbcglobal.net
Kathleen Grose	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Pathways Community Health/Compass Health Network	1010 Remington Plaza Raymore MO, 64083 PH: 816-318-4430	kgrose@pbhc.org
Liz Hagar-Mace	State Employees	Missouri Department of Mental Health	1706 E Elm St Jefferson City MO, 65101 PH: 573-522-6519	liz.hagar-mace@dmh.mo.gov
Sandra Jackson	Providers	John J Pershing Veteran's Administration	1500 N Westwood Blvd Poplar Bluff MO, 63901 PH: 573-778-4740	sandra.jackson2@va.gov
Nancy Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1544 Norwood Hills Dr O'Fallon MO, 63366 PH: 660-988-2090	nkr323@gmail.com
Toni Jordan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1408 S 10th St St Louis MO, 63108 PH: 314-241-2324	jordan.toni@ymail.com
Richard Kenney	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		103 N Windwood Carl Junction MO, 64834 PH: 417-438-5301	tkenney@mchsi.com
Eric Martin	State Employees	Department of Social Services/Medicaid	PO Box 6500 Jefferson City MO, 65102 PH: 573-522-8336	eric.d.martin@dss.mo.gov
			3024 Dupoint Circle	

Rebecca Maynard	State Employees	Dept. of Elementary & Sec. Educ./Div. of Voc. Rehab.	Jefferson City MO, 65109 PH: 573-526-7049	rebecca.maynard@vr.dese.mo.gov
Christine McDonald	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3649 Salem Dr St Charles MO, 63301 PH: 636-487-8986	christine.crypurple@gmail.com
Denise Mills	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Burrell Behavioral Health	1300 Bradford Parkway Springfield MO, 65804 PH: 417-988-5222	denise.mills@burrellcenter.com
Page Nichols	State Employees	Missouri Department of Corrections	2729 Plaza Dr Jefferson City MO, 65109 PH: 573-526-6523	pagena.nichols@doc.mo.gov
Angela Reynolds	Providers	St. Joseph Youth Alliance	5223 Mitchell Ave St Joseph MO, 64507 PH: 816-232-0050	areynolds@youth-alliance.org
Carrie Rigdon	Providers	Crider Health Center	1032 Crosswinds Court Wentzville MO, 63385 PH: 636-332-8368	crigdon@cridercenter.org
Randall Robb	State Employees	Missouri Department of Corrections	1170 State Route Z Franklin MO, 65250 PH: 660-848-2707	randall.robbs@doc.mo.gov
Barb Scheideger	Parents of children with SED	Families 4 Families	2623 Idelwood Rd Jefferson City MO, 65109 PH: 573-619-1322	Mof4f@mediacombb.net
Susan Scott	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		901 NE Independence Ave West Plains MO, 65775 PH: 417-619-4402	scscott45@yahoo.com
Mark Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		548 Co Rd 510 Wappapello MO, 63966 PH: 573-722-2115	smithmarkerdr@gmail.com
Jean Sokora	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		801 Charlesgate Dr St Louis MO, 63132 PH: 314-659-6580	iamamom23@gmail.com
Amy Stevens	State Employees	Missouri Department of Mental Health	2600 E 12th St Kansas City MO, 64127 PH: 816-482-5725	amy.stevens@dmh.mo.gov
David Stoecker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1925 E Bennett Springfield MO, 65803 PH: 417-268-7489	david.stoecker@gmail.com
Mindy Ulstad	State Employees	Missouri Department of Health and Senior Services	912 Wildwood Dr Jefferson City MO, 65109 PH: 573-526-8534	mindy.ulstad@health.mo.gov
			500 Medical Dr	

Karah Waddle	Providers	Preferred Family Healthcare	Wentzville MO, 63385 PH: 636-327-1017	karah_waddle@ssmhc.com
Stephanie Washington	State Employees	Missouri Department of Health and Senior Services	930 Wildwood Dr Jefferson City MO, 65102 PH: 573-522-2550	stephanie.washington@health.mo.gov
Janet Worthy	Providers	St. Louis Valley Hope	7451 Capilia Dr St Louis MO, 63123 PH: 314-550-9707	janetwvalleyhope@yahoo.com
Malva Yocco	Family Members of Individuals in Recovery (to include family members of adults with SMI)		786 Redstart Ellisville MO, 63021 PH: 636-348-7198	malvayocco@hotmail.com

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	30	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	16	
State Employees	8	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	14	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	15	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

- a) Public meetings or hearings? ☒ Yes ☐ No
- b) Posting of the plan on the web for public comment? ☒ Yes ☐ No
- c) Other (e.g. public service announcements, print media) ☐ Yes ☒ No

If yes, provide URL:

<http://dmh.mo.gov/mentalillness/blockgrant/>

<http://dmh.mo.gov/ada/rpts/blockgrant.html>

Footnotes: